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the JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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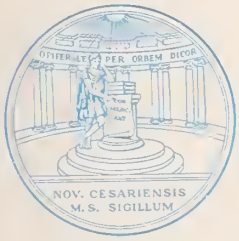

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JULY 1974
VOL. 71 No. 7

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- Federal financing limited to coverage of the poor and medically indigent.
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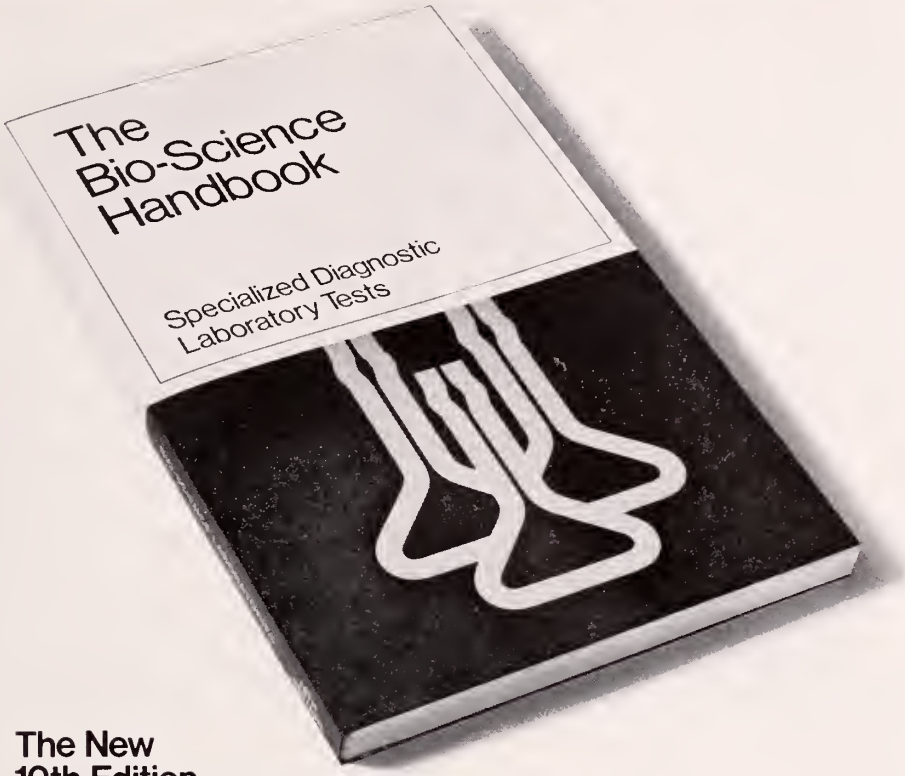

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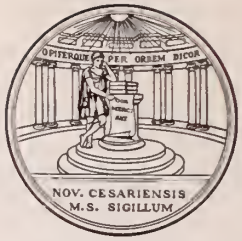

JULY 1974

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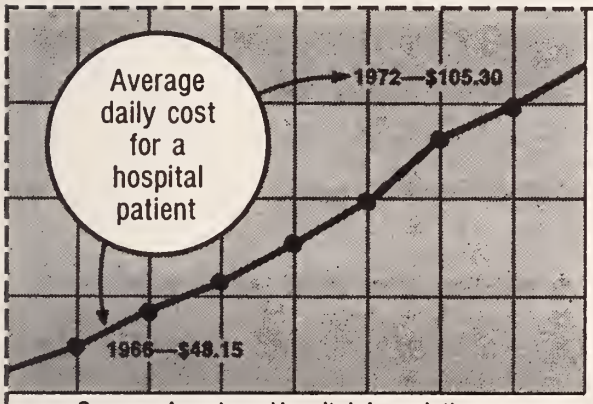

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the compatible vasodilator... no treatment conflicts reported

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Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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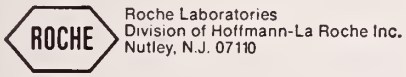
Some people develop excessive psychic tension and need your counseling

and a few may need counseling
and the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

You should be aware of the possibility of side effects in some patients and should consult the complete product information before prescribing.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

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Opinion & Dialogue

Is there a need for a drug compendium?

A drug compendiu of the type I envisio would fill a definite need for the pract ing physician. Suc compendium wou give him all th information ne essary for usi a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactio with other drugs.

The information would be based on the package insert and have the same legal status. In fac a complete compendium with co plete and current information might even eliminate the necess

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company

A drug compendium, or preferably compendia, should, I believe, be private, not federal, i sponsorship. They should contai comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every ye

Function of a Compendium

A compendium should furnish the following information or drugs in the following order: indi tions for use, side effects, adver drug reactions, contraindication drug interactions, drug dosage a the dosage forms marketed. Dru prices should not be included be cause they vary so widely and change rapidly.

No compendium should se forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing ph sician to decide, whether on the basis of the medical literature, h own clinical experience, advice colleagues, information supplie by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor how to use drugs. Rather, it mus be a reference source designed p marily to refresh his memory as drugs he may not use regularly.

a package insert in many in-
nces. This would constitute a
stantial saving for the manu-
turer.

By a complete compendium,
not mean a volume of prohibi-
size. You don't need a book
scribing 25,000 products with
enormous amount of repetition.
her, drugs should be arranged
class. Mutually applicable infor-
tion would be provided, along
n brief discussions pinpointing
erences in specific drugs of
t class. Listings would be cross-
exed in a useful way.

**er Available Documents as
rces of Information**

Existing references such as
R and the AMA Drug Evaluation
obviously useful but they are
omplete. Either they are not
ss-referenced by generic name
l do not group drugs with simi-
characteristics, or they do not
all the available and legally
rketed drugs. And some of
se omitted may be very useful.

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

---

uld in no way imply control over
practitioner's prerogatives.

y Another Compendium?

A practicable, single-volume
mpendium cannot, nor is it
cessary to, include all drugs on
market today. From my prac-
e of internal medicine for some
years, my experience as a con-
tant, and as a faculty member
our or five medical schools, I
uld estimate that a doctor uses
y 30 to 35 drugs regularly. The
72 Physicians' Desk Reference,
identally, contained about
00 entries.

As to whether there should be
ederal compendium, in my opin-
, as stated earlier, the answer is
sy—there should *not* be one. The
posal assumes that existing
mpendia are inadequate. We're
t sure of that at all. Whatever its
perfections, the present drug
ormation system in the U.S. is
en, multifaceted, pluralistic and
ensive. Good compendia exist,
well as other ample sources on
g therapy, ranging from journal
erature through AMA Drug Evalu-
on to company materials. Not
physicians may use such
rces as often or as well as they
uld, but that is the fault of the
n, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

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EDITORIALS

The 208th Annual Meeting

The successes and failures of the recent Annual Meeting can be measured objectively by the number of physicians who attended lectures and panel discussions at the scientific sessions and who visited the motion picture theatre and the exhibits. One can enumerate the attendance of committee members and others at reference committee meetings. The list of officers, fellows, delegates, and alternates in attendance can be tallied. Will this be a true measure of success?

How about the quality of the food, the view of the ocean, the weather? There is always nostalgia to help make a judgment—the great Benny Goodman, his current sextet, and that wonderful musical sound. Are these yardsticks of convention quality?

To some degree the answer must be yes. Fun and games, a dip in the pool, and a walk on the boards are necessary. Medical education is essential, but the most important ingredient of all is the business of the reference committees, the Officers, the Board of Trustees, and the House of Delegates. Observation of a House session leads us to recognize the serious attitude and devotion to purpose which each participant exuded. As in every representational body, there were factions, differences of opinion, and sometimes emotional reactions. Careful attention to these delegates at the annual meeting revealed a large measure of devotion to the common good, to the welfare of the patient, and the community, at times with what appeared as an anti-self servitude.

If one had to select a thumb-nail description of a House of Delegates' meeting, it might be "courage." It takes "guts" to face a microphone and speak one's piece on a sensitive issue, knowing full well that a large number of one's colleagues may disagree. Another word might be "patience" for it is disheartening for a reference committee to spend hours on important issues and have some or all of its recommendations and resolutions shot down by the body of convention delegates. Yet, chairman after chairman and delegate after delegate had this experience to some degree without reflecting rancor or acrimony.

There was "humor" to be seen. Like the delegate who wondered out loud, after a humdinger of a "rhubarb" between some delegates and the Speaker of the House, how the Ten Commandments would make out were they presented for discussion and vote that day.

"Leadership" was clearly apparent, and not only by elected MSNJ officers. There were delegates, having done their homework on important problems, who spoke eloquently enough to swing the opinions of other delegates to one side or another of issues.

"Flexibility" was seen in the decisions and actions of both the Speaker and the Vice Speaker, but always within the framework of the rules of order. Never was the gavel lowered with a heavy-handedness that grew out of anger or impatience.

"Respect" was obvious from delegate to delegate. Captioned was such a feeling by the delegate who told another that he did not always agree with the opinions of his colleague, but he respected the fact that his comments were carefully thought out and prepared, and clearly stated with appropriate conviction.

The 208th Annual Meeting was a worthwhile venture and a success. The Society as a whole owes a debt of gratitude to the Committee on Annual Meeting, the Subcommittees on Scientific Exhibits and Scientific Program, the Officers, Trustees, and Delegates of the Society, to the Speaker and Vice Speaker of the House, and to the Convention Manager, the Executive Director, and the entire staff.

A.K.

Stay on Your Pedestal!

Despite the intermittent "bad press" that the medical profession has received in the last decade, the physician has not been pushed off his pedestal, according to recent national opinion polls. In a survey by the Gallup Poll, "Medicine remains the top choice among adults asked to name the best profession for a young man." We must assume, in this day of sexual equality, that the same would also apply to a young lady.

The question put was, "Suppose a young man came to you and asked your opinion about taking up a profession. Assuming that he was qualified to enter any of these (9) professions, which would you first recommend to him?" The selection of medicine was overwhelmingly higher than all others, as it has been since 1950, when the Gallup organization first asked the question. In terms of confidence in its institutions, a nationwide study of adult opinion by the Harris organization indicated a retention of public esteem in medicine. This conviction contrasted with a loss of trust and a feeling of pessimism and alienation toward politicians and government officials. There was a sharp decline in confidence in the executive branch of the federal government, but a retention of support in the basic system of government in our country.

Individual physicians and organized medicine alike have an awesome responsibility to maintain this patient and public trust, which began more than two millennia ago. While doing their jobs in personal and public health, and in medical education, physicians have commitments to their patients and communities, and to their hospitals and medical colleagues. They are indebted to the teachers and responsible for their students. Not to be forgotten is a dedication to family and friends and, with all this, *self* is often overlooked.

It takes a good deal of strength, courage, and devotion to maintain one's equilibrium under such circumstances. The scrambling about that is required and natural human frailties occasionally unbalance one of us. Despite the pressures, each physician must be careful not to fall off the invisible pedestal on which public opinion continues to maintain him. A.K.

The Rising Tide of Antiscience

Horoscopes and Tarot cards have never been more popular. Otherwise sophisticated people talk of trines (favorable position between two planets that affect your life). It has become a fashion to say, "Why not try acupuncture?" There are people who swear that nothing has relieved their joint pains as swiftly as wearing copper bracelets. Vitamins are seen not simply as methods of treating vitamin deficiencies, but also as having mysterious "molecular" powers. In any large city you can find a "health food" store or counter which offers to furnish ingredients that will make you bound with joy and vigor. Even the Ouija board is making something of a comeback.

All this is, we suspect, in part, a revolt against the elitism of science. In line with the philosophy which says that there should be students on school boards, patients on hospital boards, welfare clients on the boards of welfare agencies—along with all this—comes the doctrine that nonscientists should provide a leaven of popular or "common sense" thinking on the staffs of scientific bodies. One feature is that most of the "antiscience" thinking doesn't last long and today's fresh idea goes the way of hoola hoops in as short a time. It may be that scientists have shown too little concern with the social effects of their scientific achievements, or that there has been neglect of the fact that all science, including medical, is also a social science. It is also alleged that the scientific establishment refuses seriously to investigate the claims of telepathy, acupuncture, or astrology and that in not making such investigations science brands itself as closed-mind, old-fashioned, and tyrannical. But perhaps the current "antiscience" trend itself is only a short-lived fad. Or maybe not. H.A.D.

President Boylan and Mrs. Rogers

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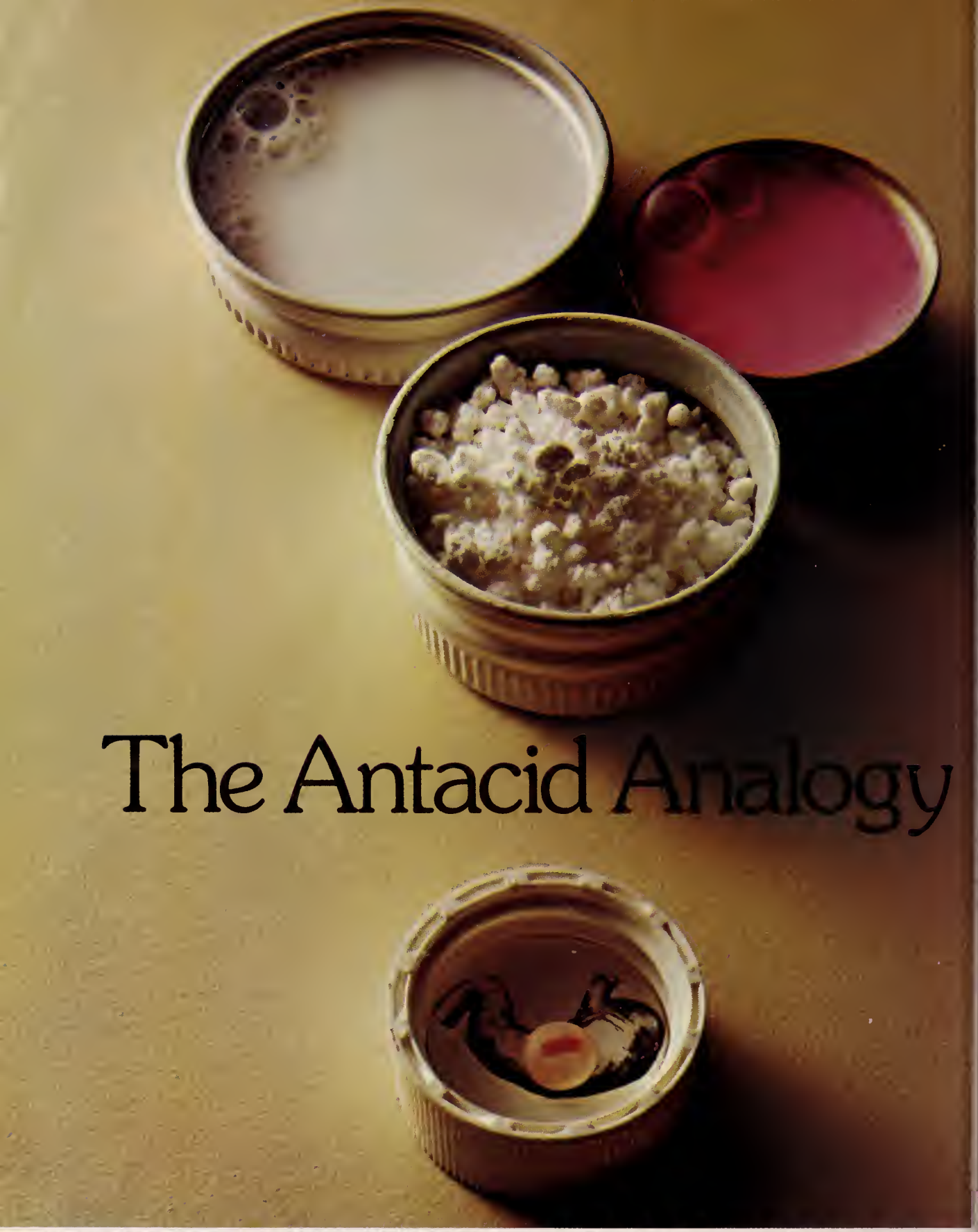

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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*Serum Potassium Level Drops During Long-Term Exercise, *Medical Tribune*, July 4, 1973.

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TRANSACTIONS

1974 House of Delegates

208th ANNUAL MEETING

The Medical Society of New Jersey

May 11-14, 1974

President Matthew Boylan

President-Elect James A. Rogers

Speaker Henry J. Minem

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ANNUAL REPORTS

President

Matthew E. Boylan, M.D., Jersey City

(Reference Committee "A")

This year with the indulgence and concurrence of the House of Delegates of The Medical Society of New Jersey, I have adopted the principle of submitting one combined Presidential Report and President's Farewell Address, rather than give you two philosophical discussions of a departing president. I hereby submit what I have decided to call "The Account of Stewardship of Your President for the Year 1973-74."

One year ago this week I assumed the office of the President of The Medical Society of New Jersey. At that time I issued a call for unity within the Society. We started off well in that vein. We had recently formed the New Jersey Foundation for Health Care Evaluation. The officers and the executive committee of the Foundation labored long and hard. There were innumerable board meetings and committee meetings. The Foundation was incorporated. Funding was provided on a monthly basis. All seemed to be progressing smoothly and well until Secretary Weinberger suddenly announced that there would be not one but eight PSRO's in New Jersey. All is not lost. The Foundation may become the center, the heart, and the data base in its function as the "umbrella support center" for all eight PSRO's. We must continue to be united and function under one unified body with eight components or else we may fail and have some governmental or other corporate body take over this function. Then we will no longer have control but instead shall be directed, or dictated to as vulnerable individuals. This would certainly result in divisiveness, and fragmentation, and, ultimately, I am afraid, in dissolution and abandonment of our united organization and those principles to which we have adhered and which we hold and have held so loftily these past two hundred and seven years. I do not believe we should take this situation lightly nor do I believe we should surrender our individuality so apathetically. I strongly request you to consider consolidation of eight units forged under *one* central organization that can provide guidance and unification. This is available to you through the continued existence of the New Jersey Foundation for Health Care Evaluation in New Jersey. Please give us your support.

The Board of Trustees has been vitally interested in the topic of "Certificate of Need." It submitted a definition of the "private practice of medicine" which the Health Care Administration Board of the State Department of Health does not wish to accept. The Board of Trustees, however, shall not vary from this interpretation without compelling justification. There has been a contradictory interpretation of "Certificate of Need" introduced by the Hospital Association of New Jersey. This view is at variance with the original concept of the law, and I am convinced the Medical Society should continue to oppose it as it pertains to the private practice of medicine.

In the last two years the Board of Trustees inaugurated a program of inviting two or three presidents of county medical societies to attend the monthly meetings of the Board of Trustees of The Medical Society of New Jersey, so that the individual county society officers might observe the deliberations of the Board and the functions and operations of the Committees and Councils of the State Society. The communications forwarded from the county societies are also discussed and deliberated here. In the past year I have also invited the executive secretaries of the county socie-

ties to attend the monthly meetings of the Board of Trustees with their presidents and presidents-elect so that they may know and understand the continuum of administration and function within the Society.

Recently upon recommendation of the Council on Legislation, I appointed an Ad Hoc Committee, composed of five members, for the express purpose to "study and redefine the role and function of the Council of Legislation." The impetus for the appointment of this Ad Hoc Committee was brought to bear by the recent load placed upon the Council.

In this meeting there were referred for study, examination, and recommendation two hundred and fifty plus legislative measures. This has become an unmanageable burden. A streamlining function must be considered, and this task has been referred to the Ad Hoc Committee, as recommended.

Last year the House of Delegates mandated an expanded, aggressive public relations program. In this area, a new executive assistant in charge of public relations was retained. Within a short period of time this new executive assistant and the Council on Public Relations became involved over a regionally televised program concerning the practice of medicine. Through their vigorous pursuit, the producers of the program apologized for parts of the presentation and the sponsor of the program withdrew further financial support. As a result of this action a new meaningful program of public relations is in the making. Locally, on the state educational channels a whole series of medical subjects has been and is being continuously presented for viewing under the auspices of the Council on Public Relations.

Along the lines of accountability as your President, I would like to present a record of the last year:

First, I will hopefully be recorded as an active, participating, and at times, aggressive President. I did not assume the office merely for prestige and honor, but undertook the title to give my best to this Society. Now I shall give you an accounting:

Within this year 1973-74 I have attended 31 meetings at The Medical Society of New Jersey headquarters; 49 meetings outside the Medical Society but within the State of New Jersey; 12 meetings outside the State of New Jersey to such places as Maryland, Pennsylvania, Chicago, American Medical Association, California, and Delaware. In all I attended and participated in 104 meetings, and many and varied programs including testimony before State agencies, Governors' panels and committees, in behalf of Medicine in general and The Medical Society of New Jersey in particular.

I am most honored and appreciative of having been elected by you, the House of Delegates of The Medical Society of New Jersey, and of having served as your one hundred and eighty-third President.

I have given you an account of my stewardship and now hand over the office to your new President, James A. Rogers, M.D., of Passaic County.

Filed with commendation to the President (page Tr 137)

Speakers' Platform—1st Session, House of Delegates

Secretary

Louis F. Albright, M.D., Spring Lake

(Reference Committee "A")

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended the annual meeting of the American Medical Association in New York and the Clinical Convention in Anaheim, California —serving in a dual role as MSNJ Secretary and an AMA Alternate Delegate. At state level, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

Membership

(as of December 31, 1973)

Active: Paid	7,599	
Exempt	617	8,216**
*Associate: Paid		0
State Emeritus		355
Total of Above		8,551
State Honorary		8
New and Reinstated Members:		
Active		555
*Associate		0
Transfers within the state		20
Transfers out-of-state and resignations		93
Members deceased		111
Members dropped:		
Active: (non-payment of dues)	81	
(N.J. licensure revoked)	1	
*Associate (non-payment of dues)	0	82

*Associate membership designates Interns and Residents.

**Adjusted for transfers out-of-state, resignations, and deaths.

AMA Membership

A total of 5,992 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates continued to total six delegates—one for each thousand members, or fraction thereof.

Membership Directory

Work is being carried forward to achieve the publication of the next edition of the *Membership Directory* in the fall of 1974, when, it is expected, distribution will be made to the entire membership.

The new *Directory* will embody the same features as that of the 1972-73 edition. These include: (1) the presentation in bold print of the "type of practice" in the individual listing directly following the name, and preceding the address; (2) a single asterisk (*) to designate "Armed Forces," a single dagger (†) to designate associate, a double dagger (††) to designate emeritus membership, and a triple dagger (†††) to designate affiliate membership; (3) the zip code will appear as the last item in each individual listing; (4) the hospital section of the *Directory* will again include the listings of hospital staffs; (5) the special membership supplement section—which now includes the Constitution and Bylaws of MSNJ, the AMA Principles of Medical Ethics, the Basic Concepts Underlying the Provision of Professional Medical Care, Legal Obligations Affecting Medical Practitioners in New Jersey, Guides for Physicians—Hospital Relationships in New Jersey, and a list of Poison Control Centers in New Jersey.

Verification data sheets supplied to the membership will form the basis for the biographical data to be published in the 1974-75 edition, as did similar data sheets which were supplied to publish the 1972-73 *Directory*. With the cooperation of the membership, it is the hope of your Committee to make this forthcoming *Directory* the most complete and accurate edition yet published.

Filed with commendation to retiring secretary (page Tr 138)

Treasurer

Samuel J. Lloyd, M.D., Trenton

(Reference Committee "B")

This 1974 interim financial report of your Treasurer has been prepared from the books and records of The Medical Society of New Jersey.

The Balance Sheet is presented as of March 31, 1974 and May 31, 1973. Figures at March 31, 1974 have not been audited, for the reason that the fiscal year of the Society does not end until May 31, 1974. The figures at May 31, 1973 have been abstracted from the report of audit dated August 9, 1973.

The Statement of Revenue, Expenditures, and General Surplus Unappropriated present the transactions of the Society for the ten months ended March 31, 1974 and the year ended May 31, 1973.

Revenues have been examined on a test basis and disbursements have been test checked to approved supporting vouchers by the Society's independent accountants. The cash balances at March 31, 1974 were reconciled with the bank statements but were not confirmed direct with the depositories. Revenues from Counties for dues assessments were checked in detail to reports on file, but were not confirmed with County Treasurers at this time. Investments were not physically examined or confirmed at March 31, 1974.

These financial statements have been prepared in a form similar to the annual audit report, in order to show in greater detail the assets, liabilities, and fund balance, operating revenue and expenditures of the Society, in conformity with Resolution #28 approved by the 1968 House of Delegates under the heading "Annual Financial Report."

Liabilities and Fund Balances

	March 31, 1974	May 31, 1973
Liabilities:		
Unexpended Budget Appropriations (Page Tr 10)	$ 142,532.71	$ —
Accounts Payable	11,691.07	60,674.24
Payroll Taxes Payable	4,089.21	510.61
AMA Collection Fees Payable	316.25	3,642.10
American Medical Association (Page Tr 13)	49,280.00	—
Due to Physicians' Relief Fund	40,883.46	38,587.50
Due to Medical Student Loan Fund	73,503.00	81,000.00
Deferred Income—Assessments Collected Applicable to Succeeding Year (Page Tr 12)	313,098.35	269,360.00
Other Liabilities	3,850.00	613.25
Funds for Specific Purposes:		
House Restoration and Replacement	7,339.24	5,339.24
Land, Building and Equipment	317,927.93	317,927.93
Maternity Service Record Books	6,252.50	678.96
Royalties on "The Healing Art"	2,058.00	2,068.50
"The Healing Art" Books	6,286.56	6,318.62
Membership Directory	6,087.64	3,027.64
Annual Meeting	19,149.61	—
General Fund Balance (Unappropriated)	124,643.66	180,426.52
	$1,128,989.19	$970,175.11

Balance Sheet—General Fund (Unaudited)

Assets	March 31, 1974	May 31, 1973
Cash (Page Tr 12)	$ 39,568.91	$ 25,481.37
General Fund Investment Account—at cost (Page Tr 13)	450,484.02	272,412.56
General Fund Investment Portfolio—at cost (Page Tr 14)	188,477.56	190,448.60
General Fund Saving Certificates (Page Tr 14)	30,000.00	45,000.00
Accounts Receivable	6,718.84	15,867.78
Inventories—at cost		
Maternity Service Record Books	6,252.50	678.96
"The Healing Art" Books	8,344.56	8,387.12
Land, Building and Equipment—at cost	317,927.93	317,927.93
Deferred Expense—Construction Loan	73,503.00	81,000.00
Accruel Interest	7,449.09	8,819.05
Other Assets	262.78	4,151.74
	$1,128,989.19	$970,175.11

Statement of Revenue, Expenditures and General Fund Balance (Unappropriated) (Unaudited)

	Ten Months Ended March 31, 1974	Year Ended May 31, 1973
Revenue:		
Assessments Earned (Page Tr 12)	$518,421.65	$466,855.00
Interest Income from General Fund Investments (Page Tr 13)	7,235.37	8,885.57
Interest Income from General Fund Savings Certificates (Page Tr 14)	1,294.50	2,163.61
Interest Income from General Fund Investment Portfolio (Page Tr 14)	8,324.29	12,016.33
Maternity Service Record Book Sales	533.82	964.32
"The Healing Art" Book Sales	59.50	34.00
Miscellaneous Income	———	41.39
Total Revenue	$535,869.13	$490,960.22
Expenditures—Budget Appropriations (12 months)—(Page Tr 10)	$558,989.00	$457,090.64
Excess or (Deficit) of Revenue over Expenditures before Medical Journal Deficit and Miscellaneous Transfers	($ 23,119.87)	$ 33,869.58
Other Decreases:		
Medical Journal Deficit (Page Tr 11)	$ 25,176.51	$ 15,550.95
Annual Meeting Deficit	———	5,192.29
Prior Year's Expenditures paid in Current Year	1,379.12	5,697.43
Excess Construction Expenditures	———	5,023.34
New Jersey Foundation for Health Care Evaluation Expenditures	———	8,691.99
Maternity Service Record Book Costs—New Edition	6,107.36	———
	$ 32,662.99	$ 40,156.00
Net Decrease in Fund Balance	($ 55,782.86)	($ 6,286.42)
General Fund Balance (Unappropriated):		
Balance, Beginning	$180,426.52	$186,712.94
Balance, Ending	$124,643.66	$180,426.52

Statement of Expenditures—General Fund
For the Ten Months Ended March 31, 1974
(Unaudited)

Account	Adopted Budget	Total Expended	Balance Unexpended
Executive Salaries	$ 74,523.00	$ 64,175.94	$ 10,347.06
General Staff Salaries	166,301.59	132,365.12	33,936.47
General Executive Office Expenses	22,500.00	20,674.22	1,825.78
Executive Travel	6,900.00	5,808.11	1,091.89
House Maintenance	31,100.00	26,501.40	4,598.60
Treasurer	8,000.00	6,526.27	1,473.73
Finance and Budget Committee	75.00	.48	74.52
Secretary	400.00	———	400.00
Salary Taxes	17,089.41	14,029.06	3,060.35
Insurance	12,300.00	10,944.31	1,355.69
House Reserve	12,200.00	12,978.28	(778.28)
MSNJ Pension Plan	1,700.00	1,511.12	188.88
MSNJ Building Loan	13,500.00	10,874.57	2,625.43
Legislation	9,200.00	4,579.53	4,620.47
Council on Public Health	2,700.00	1,517.32	1,182.68
Council on Public Relations	46,000.00	39,796.35	6,203.65
Council on Medical Services	700.00	220.36	479.64
Council on Mental Health	1,600.00	393.06	1,206.94
President & Presidential Officers	15,600.00	12,913.66	2,686.34
AMA Delegates	15,000.00	11,023.35	3,976.65
Woman's Auxiliary	5,600.00	3,520.74	2,079.26
Committee on Medical Education	35,300.00	1,945.96	33,354.04
Conference Groups	500.00	241.83	258.17
Membership Directory	16,000.00	14,700.51	1,299.49
Committee on Emergency Medical Care	300.00	122.09	177.91
Credentials & Membership Committee	1,000.00	1,015.39	(15.39)
Archives & History	100.00		100.00
Project Hope—Vietnam	6,000.00	———	6,000.00
Committee on Medical Defense and Ins.	500.00	146.50	353.50
Membership Inq. & Complaint Committee	1,000.00	72.69	927.31
Board of Trustees	7,500.00	2,468.57	5,031.43
Contingent	10,000.00	7,323.00	2,677.00
Judicial Council	500.00	100.06	399.94
Legal	7,300.00	4,605.00	2,695.00
Medical Student Loan Fund	6,000.00	———	6,000.00
Authorized Reimbursement for Representatives to Meetings	4,000.00	3,361.44	638.56
Total Budget Expenditures	$558,989.00	$416,456.29	$142,532.71

Balance Sheet
Physician's Relief Fund
(Unaudited)

Assets	Ten Months Ended March 31, 1974	Year Ended May 31, 1973
Due from General Fund	$40,883.46	$38,587.50
Fund Balance	$40,883.46	$38,587.50

Statement of Revenue and Fund Balance
Physicians' Relief Fund
(Unaudited)

	Ten Months Ended March 31, 1974	Year Ended May 31, 1973
Revenue:		
Income from Investments	$ 2,295.96	$ 1,837.50
Total Revenue	$ 2,295.96	$ 1,837.50
Fund Balance, Beginning	$38,587.50	$36,750.00
Fund Balance, Ending	$40,883.46	$38,587.50

Statement of Revenue, Expenditures
Medical Journal
(Unaudited)

	Ten Months Ended March 31, 1974	Year Ended May 31, 1973
Revenue:		
Members' Subscriptions Earned	$23,721.25	$25,252.50
Advertising:		
State Medical Journal Advertising Bureau	28,439.76	35,853.64
Local	12,223.21	14,909.35
Classified	265.80	326.70
Cooperative Rebate	762.08	2,571.99
Subscriptions and Extra Copies	1,462.82	2,037.04
Reprints — Net	433.96	2,255.56
Illustrations	———	527.65
Total Revenue	$67,308.88	$83,734.43
Expenditures:		
Publication	$58,526.38	$64,670.90
Salaries	20,189.56	18,577.48
Advertising Manager's Commission	4,492.30	5,989.44
Commissions — Local	5,071.20	6,137.38
Discounts	727.07	934.03
Administrative Expenses	———	315.81
Payroll Taxes	1,494.31	1,098.17
Insurance	106.74	315.64
Travel	266.75	12.50
Illustration Expenses	516.68	905.73
Office Expenses	1,094.40	52.50
Bad Debts	———	275.80
Total Expenditures	$92,485.39	$99,285.38
Excess of Expenditures over Revenue	$25,176.51	$15,550.95

Balance Sheet
Medical Student Loan Fund
(Unaudited)

Assets	Ten Months Ended March 31, 1974	Year Ended May 31, 1973
Cash (Page Tr 12)	$ 9,919.97	$ 12,673.47
Certificates of Deposit (Page Tr 14)	15,000.00	45,000.00
General Investments—at cost (Page Tr 14)	77,350.51	48,566.67
Notes Receivable—Secured by Life Insurance Policies	231,919.00	207.469.00
Due from General Fund	10,874.57	11,854.17
Accrued Interest	340.40	660.02
Loans Receivable—General Fund	73,503.00	81,000.00
Fund Balance	$418,907.45	$407,223.33

Note. The Fund balance includes $7,112.00 designated as the Albert Barker Kump Memorial Grant and $5,055.00 designated as the Joseph E. Mott Memorial Grant.

Statement of Revenue and Fund Balance
Medical Student Loan Fund
(Unaudited)

	Ten Months Ended March 31, 1974	Year Ended May 31, 1973
Revenue:		
Contributions:		
General	$ 2,490.30	$ 18.739.92
Albert Barker Kump Memorial Grant	250.00	250.00
General Fund Contribution	——	6,000.00
Income from Investments	3,789.56	286.66
Income on Certificates of Deposit	1,328.36	5,755.69
Interest on Notes Receivable	430.77	254.35
Interest on Loans Receivable—		
General Fund	3,377.57	2,854.17
Bad Debts Recovery	15.00	20.00
Miscellaneous Income	2.56	——
Total Revenue	$ 11,684.12	$ 34,160.79
Bad Debt Recovery (Expense)	——	80.00
Net Revenue	$ 11,684.12	$ 34,080.79
Fund Balance, Beginning	$407,223.33	$373,142.54
Fund Balance, Ending	$418,907.45	$407,223.33

Analysis of Cash, Certificates of Deposit, Investments and Income Thereon
March 31, 1974
(Unaudited)

General Fund:		
New Jersey National Bank:		
Treasurer's General Checking	$24,568.91	
Executive Account Checking	14,500.00	
Office Petty Cash Fund	500.00	
Total		$39,568.91
Medical Student Loan Fund:		
New Jersey National Bank:		
Treasurer's Checking Account		$ 9,919.97

Schedule of State Assessments Collected
For the Ten months Ended March 31, 1974
(Unaudited)

County	1974 Dues	1973 Dues	Net State Assessments
Atlantic	$ 15,400.00	$ 1,050.00	$ 16,450.00
Bergen	84,900.00	2,940.00	87,800.00
Burlington	20,120.00	665.00	20,785.00
Camden	43,500.00	1,295.00	44,795.00
Cape May	3,600.00	105.00	3,705.00
Cumberland	9,800.00	210.00	10,010.00
Essex	125,080.00	4,880.00	129,960.00
Gloucester	9,500.00	———	9,500.00
Hudson	30,740.00	4,730.00	35,470.00
Hunterdon	6,200.00	70.00	6,270.00
Mercer	23,100.00	3,045.00	26,145.00
Middlesex	40,800.00	1,645.00	42,445.00
Monmouth	32,820.00	2,695.00	35,515.00
Morris	36,300.00	945.00	37,245.00
Ocean	14,800.00	840.00	15,640.00
Passaic	59,020.00	1,120.00	60,140.00
Salem	3,600.00	70.00	3,670.00
Somerset	9,020.00	700.00	9,720.00
Sussex	6,200.00	420.00	6,620.00
Union	59,600.00	210.00	59,810.00
Warren	4,800.00	140.00	4,940.00
Total	$638,900.00	$27,775.00	$666,675.00

Reconciliation of State Assessment Account
For the Ten Months Ended March 31, 1974
(Unaudited)

Unearned Assessments, June 1, 1973			$269,360.00
Collections—1973 Members' and Associate Members' Dues		$ 27,775.00	
Less: Annual Meeting Assessment	$ 981.25		
Medical Journal Assessment	1,373.75		
		$ 2,355.00	
			$ 25,420.00
Collections—1974 Members' and Associate Members' Dues		$638,900.00	
Less: Annual Meeting Assessment	$15,962.50		
Medical Journal Assessment	22,347.50		
New Jersey Foundation for Health Care Evaluation Assessment	63,850.00		
		$102,160.00	
		$536,740.00	
Less: 1974 Assessments Applicable to Year Ending May 31, 1975—($536,740.00 x 7/12)		$313,098.35	
			$223,641.65
Earned Assessments for the Ten Months Ended March 31, 1974			$518,421.65

Analysis of General Fund Investments and Income Thereon
March 31, 1974
(Unaudited)

New Jersey National Bank: Certificate of Deposits	Due Date	Cost	Maturity Value	Yield	Interest Income
#3494	4/22/74	$105,000.00	$105,000.00	7.75%	$ 860.70
#3504	4/08/74	105,000.00	105,000.00	8%	599.20
U.S. Treasury Bill	4/18/74	88,198.80	90,000.00	7.98%	1,501.00
U.S. Treasury Bill	5/09/74	78,609.40	80,000.00	6.951%	967.00
U.S. Treasury Bill	5/23/74	39,281.72	40,000.00	6.85%	390.60
U.S. Treasury Bill	5/23/74	34,394.10	35,000.00	7.018%	201.76
		$450,484.02	$455,000.00		$4,480.26
Income from Investments redeemed during period					$5,051.07
					$9,531.33
Less: Interest Income on Physician's Relief Fund					$2,295.96
General Fund Investment Income					$7,235.37

Schedule of Special Assessments Collected
For the Ten Months Ended March 31, 1974
(Unaudited)

County	American Medical Association Dues
Atlantic	$ 15,840.00
Bergen	62,700.00
Burlington	18,315.00
Camden	43,010.00
Cape May	3,740.00
Cumberland	6,270.00
Essex	105,600.00
Gloucester	9,350.00
Hudson	26,510.00
Hunterdon	6,050.00
Mercer	27,335.00
Middlesex	38,390.00
Monmouth	20,295.00
Morris	29,535.00
Ocean	10,230.00
Passaic	30,745.00
Salem	3,520.00
Somerset	7,150.00
Sussex	5,005.00
Union	51,480.00
Warren	4,950.00
Total	$526,020.00

Reconciliation of Special Assessments
For the Ten Months Ended March 31, 1974
(Unaudited)

	American Medical Association
Balance Payable, June 1, 1973	$ 19,800.00
Assessments collected per above	526,020.00
	$545,820.00
Remitted to AMA	496,540.00
Balance Payable, March 31, 1974	$ 49,280.00

Analysis of General Fund Savings Certificates and Income Thereon
March 31, 1974
(Unaudited)

	Cost	Rate of Interest	Interest Income
First National Bank of Spring Lake Certificate Number 1752	$15,000.00	5½%	$ 638.02
South Jersey National Bank Certificate Number 2101	15,000.00	5%	625.02
	$30,000.00		$1,263.04
Income from Certificates redeemed during period			31.46
General Fund Savings Certificate Income			$1,294.50

Analysis of Investment Portfolio and Income Thereon
March 31, 1974
(Unaudited)

Description	Due Date	Yield to Maturity	Cost	Maturity Value	Interest Income
Fed. Nat'l. Mortgage Assoc.	12/10/74	6.1%	$ 20,000.00	$ 20,000.00	$1,017.07
Fed. Nat'l. Mortgage Assoc.	6/10/75	5.25%	20,000.00	20,000.00	874.65
Federal Intermediate Credit Bank	4/1/74	7.5%	40,854.17	40,000.00	645.83
U.S. Treasury Bill	5/9/74	6.98%	39,306.49	40,000.00	461.88
U.S. Treasury Bill	6/20/74	8.04%	48,998.00	50,000.00	83.50
U.S. Treasury Bill	8/29/74	7.38%	19,318.90	20,000.00	85.13
			$188,477.56	$190,000.00	$3,168.06
Income from Investments redeemed during period					5,156.23
Total Interest Income from Investment Portfolio					$8,324.29

Analysis of Medical Student Loan Fund Investment Account and Income Thereon
March 31, 1974
(Unaudited)

New Jersey National Bank:	Due Date	Yield to Maturity	Cost	Maturity Value	Interest Income
Certificate of Deposit 223610	4/17/74	5.5%	$15,000.00	$15,000.00	$ 684.42
U.S. Treasury Bill	5/02/74	7.4%	9,820.61	10,000.00	119.47
U.S. Treasury Bill	6/27/74	8.3%	19,595.40	20,000.00	13.50
U.S. Treasury Bill	9/26/74	8.231%	47,934.50	50,000.00	34.41
			$92,350.51	$95,000.00	$ 851.80
Income from Investments redeemed during period					$4,266.12
Total Interest from Investments					$5,117.92

Filed with commendation to the Treasurer (page Tr 140)

Board of Trustees

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "A")

All significant actions taken by the Board of Trustees at regular meetings held in the course of the year now closing have been reported in *The Journal* and have thus been called to the attention of the general membership. In addition, full copies of all Board minutes are transmitted to the presidents, secretaries, and executive secretaries of component societies, for reference and report at county meetings. In this report, therefore, it seems necessary and desirable to emphasize by specific mention only those items of particular significance that are not reflected elsewhere in the individual reports of councils and committees.

Dr. David Eckstein of Trenton was re-elected by the Board to serve as Secretary during 1973-74. Commendation is due him and all the other Trustees and Officers for their conscientious performance during the past year.

The Board recorded its profound grief at the death of Dr. Henry A. Davidson, Editor of *The Journal,* who, by his literary genius, kindly wit, and professional knowledge consistently reflected credit upon the society.

Since its last report to the House, a total of 11 meetings of the Board will have been held. Out of these 11 meetings, 2 are scheduled before the first session of the House of Delegates. The items from those meetings which must be directed to your attention will be the subject of a supplemental report to the House.

Filed (page Tr 137)

Ad Hoc Committee to Study Apportionment of Delegates

(Reference Committee "A")

At the final session of the 1973 House of Delegates, the question of apportionment of representation at future Houses was referred to the Board of Trustees for evaluation and disposition.

The Board empowered the President (May 15, 1973) to appoint an ad hoc committee to study the apportionment problem, with the assistance of a statistician, and directed that a report be prepared for presentation at the Fall Conference of Presidents and Presidents-Elect.

The President appointed the following to serve as the Ad Hoc Committee: Doctors Meyer L. Abrams, Charles L. Cunniff, William J. D'Elia, John S. Madara, and James S. Todd.

On Wednesday, October 10, 1973, a meeting was held to consider the report of the statistician and to prepare recommendations for the Board of Trustees. Present were: James S. Todd, M.D., Chairman, Pro Tempore; John S. Madara, M.D., and Charles L. Cunniff, M.D. Excused were: William J. D'Elia, M.D., Chairman, and Meyers L. Abrams, M.D. Also present were Mr. Maressa and Mr. Lucci.

The report supplied by Groendyke and Company indicated that, under the present system of apportioning delegates, the 1974 House would result in a total of 415 elected delegates based upon a December 31, 1973, close-out figure of 8,300 members. Further, this total of delegate representation could be expected to increase 2 per cent each year thereafter. It was also noted that if the Society alters membership requirements pursuant to the State Board action concerning citizenship, a higher growth rate should be anticipated.

Meeting on October 21, 1973, the Board approved the following recommendations, which conform to the statistical data presented, contained in the Committee's report:

1. That the elected delegation to The Medical Society of New Jersey House not exceed 400 members;

2. That, as soon as possible after the close of the individual calendar years, the Secretary be authorized to establish the apportionment ratio for elected delegates, bearing in mind that the total number of elected delegates should be as close to, but not in excess of, 400 as is possible to maintain;

3. That, in accordance with established custom, the Secretary, in early January of each calendar year, notify the component societies as to the number of elected delegates to which they are to be entitled for the pending annual meeting.

Filed (page Tr 137)

Committee on Long Range Planning and Development
(Reference Committee "A")

Early in the administrative year, the Board determined to revitalize and continue the Committee on Long Range Planning and Development. The President, in the ensuing months, received a number of communications from fourteen component societies and careful consideration was given to the over-all problem. The President completed his study and presented the following to the Board for consideration.

1. The number of members on the Committee should not be fixed.

2. The emphasis, as indicated by the previous Board discussion, should be on members that have thus far not been active on the State level, although a few members should be drawn from those physicians active in MSNJ affairs.

3. There should be no maximum or minimum tenure except that initial appointments should be for at least two years and there is no need to stagger terms. Terms after the initial two-year period should be reconsidered by the Board on an annual basis.

4. The Executive Director should be assigned to function as staff to the Committee.

The Committee is composed of the following members:

William J. D'Elia, M.D., *Chairman,* Monmouth County
Alfred A. Alessi, M.D., Bergen County
H. Oliver Brown, M.D., Union County
Leon C. Edwards, M.D., Somerset County
Edward P. Healey, M.D., Passaic County
Mario E. Jascalevich, M.D., Hudson County
Philip J. LoPresti, M.D., Camden County
Kenneth Tuttle, M.D., Hunterdon County
Benjamin Wolfson, M.D., Gloucester County

Filed (page Tr 137)

Investigation of "Medical Centers" or "Health Centers"
(Reference Committee "A")

The 1973 House of Delegates adopted a substitute resolution for resolution #29, which called upon the State Board of Medical Examiners to investigate the growing number of store-front, self-styled "Medical Centers" or "Health Centers" in Passaic County and throughout the State to determine whether they are operating within legal parameters as set forth in the Medical Practice Act of New Jersey.

MSNJ called the matter to the attention of the State Board following the Annual Meeting. Efforts thus far have been hampered by the lack of bi-lingual investigators. Progress is being made, however, and several such operations in other areas have been closed.

Filed (page Tr 138)

Joint Conference of Presidents and Presidents-Elect of Component Societies
(Reference Committee "A")

Once again the Board continued its precedent of sponsoring conferences for presidents and presidents-elect of component societies. The fall conference was held on Sunday, October 21, 1973. A total of 22 presidents, presidents-elect, and other officers represented 14 component societies. This conference included a series of speakers from among the society's council and committee chairmen, who addressed the group and answered questions on significant programs and policies of MSNJ.

The spring conference was held on Sunday, March 17, 1974. A total of 20 officers represented 12 component societies. The format for this meeting varied in that conferees submitted agenda items which were discussed during the morning program and then later re-

ported to the Board during the joint afternoon session.

Filed (page Tr 138)

MSNJ Board Meetings—Invited Guests
(Reference Committee "A")

The Board continued its precedent of inviting the presidents of the component societies to regular Board meetings on a rotating basis. This year, executive secretaries of component societies were also invited to attend the sessions of the Board simultaneously with their presidents.

Filed (page Tr 138)

Workshop Conference—Component Society Executives
(Reference Committee "A")

On October 23, a workshop conference of component society executives was held at MSNJ Headquarters. The executive secretaries of all component societies had been invited to meet with MSNJ staff. Although only seven counties were represented, the Executive Director reported that it afforded a meaningful experience for all. It is intended that these sessions will continue on a quarterly basis.

Filed (page Tr 138)

MSP Board of Trustees Nominations
(Reference Committee "C")

Medical-Surgical Plan of New Jersey has submitted the following nominees for terms on the Board of Trustees of Medical-Surgical Plan of New Jersey, as indicated:

Three-year term (1974-1977):

Name	*Type of Practice*	*Member of Component Society*
Edwin H. Albano, M.D.	Pathologist	Essex County
William M. Chase, M.D.	Internist	Essex County
Lloyd M. Felmly	Retired Newspaper Editor	—
John Kelley	Labor Leader	—
Samuel J. Lloyd, M.D.	Medical Consultant	Mercer County
Theron L. Marsh	Banker	—
Zelda Paulsen	Businesswoman	—
Rudolph C. Schretzmann, M.D.	Obstetrician	Bergen County
Charles O. Tyler, M.D.	Pediatrician	Camden County

The following persons will continue membership on the Board until the expiration of their terms in the year indicated—or until their successors are elected and qualified:

Terms expiring 1975:

Name	*Type of Practice*	*Member of Component Society*
Donald T. Akey, M.D.	Surgeon	Middlesex County
Robert G. Boyd	Businessman	—
Joseph A. Cox, M.D.	Anesthesiologist	Union County
Charles L. Cuniff,	Internist	Hudson County
Frederick L. Hipp, Ed.D.	Executive Vice-President New Jersey Educational Association	—
Josephine B. Janifer	Social Worker	—
William Mortenson	Businessman	—
Warren H. Simmons, Jr.	Businessman	—
Sidney I. Simon, Ph.D.	College Professor	—
Morgan Sweeney	Labor Leader	—
Robert E. Verdon, M.D.	General Practitioner	Bergen County

Terms expiring 1976:

Name	*Type of Practice*	*Member of Component Society*
A. Guy Campo, M.D.	General Practitioner	Gloucester County
Edgar P. Eaton, Jr.	Businessman	—
Mortimer J. Fox, Jr.	Businessman	—
Joseph M. Keating, M.D.	Obstetrician	Passaic County
John J. McGuire, M.D.	Surgeon	Essex County
Walter H. Miller, D.O.	Osteopath	—
Henry J. Mineur, M.D.	Internist	Union County
John R. Nevin	College Administrator	—
Ronald K. Seywert	Businessman	—
John F. Waters	Labor Leader	—

Not included in the preceding list of members serving on the Board of Trustees are the Chairman of the Board of Trustees of Hospital Service Plan of New Jersey and the President of The Medical Society of New Jersey, each of whom serve during their respective terms of office in those organizations.

Approved (page Tr 142)

Development of a Medical Education Program for South Jersey
(Reference Committee "D")

On September 26, 1973, Governor William T. Cahill directed the administration of the College of Medicine and Dentistry of New Jersey to proceed with planning for the development of a medical education program for South Jersey. A feasibility study for this project was completed during the period from the Spring of 1972 to the Summer of 1973. The results of this study indicate the need for such an educational endeavor.

The Board of Trustees and the administration of the College believe that one of the initial steps in the forward movement of this program is the identification of appropriate candidates for the position of dean of the school.

Request was made of the Board, at its October 21 meeting, that MSNJ submit to the President of the College suggestions for membership on an Advisory Committee that would work with the Board and the administration of the College in identifying dean candidates and assisting the College in its planning in South Jersey.

The following names were submitted to the President of the College:

Herbert D. Axilrod, M.D.
Richard H. DuPree, M.D.
Frank J. Hughes, M.D.
Lawrence B. Owen, M.D.

Filed (page Tr 144)

Logan College of Chiropractic
(Reference Committee "D")

At its November meeting, the Board was informed that the United States Office of Education had announced that the Logan College of Chiropractic was to become an institution of higher learning. This action was brought about by the rules promulgated by the United States Office of Education establishing a three-institution procedure by which an unaccredited institution may become an "institution of higher learning" without having been accredited by a recognized accrediting agency.

The New Jersey Delegation to the AMA was instructed to introduce an emergency resolution calling upon the AMA to seek the rescission of the decision.

At the 1973 AMA Clinical Convention the House of Delegates adopted the New Jersey resolution and denounced recognition by the United States Office of Education of a chiropractic school as an institution of higher learning. The New Jersey submittal was the only late resolution allowed by the House.

Filed (page Tr 144)

School of Allied Health Professions
(Reference Committee "D")

The College of Medicine and Dentistry of New Jersey as directed in the Master Plan for Health Professions Education for the State of New Jersey and, in keeping with its mission to develop a statewide resource for health education and health care delivery, informed MSNJ in October that it was in the process of establishing a Search Committee to identify candidates for the position of Dean of the School of Allied Health Professions.

The Committee is to be composed of representatives of various groups including current college faculty members, allied health professionals, administrators, representatives of professional organizations, students, community and house staff. The Committee will canvass and search for candidates for this position and submit to the President of the College for his consideration a slate of no less than three candidates acceptable to the majority. Following the President's review, he will either nominate a candidate for consideration by the Board of Trustees of the College or, after further consultation with the Committee, request another slate of candidates.

MSNJ submitted the following list of individuals to serve on the Search Committee:

John J. Crosby, Jr., M.D.
William A. Dwyer, Jr., M.D.
Marvin N. Solomon, M.D.

Filed (page Tr 144)

Certificate of Need
(Reference Committee "F")

In September, the Board of Trustees was informed that the State Commissioner of Health had notified a group of radiologists in northern New Jersey that they must cease and desist their office practice until they acquired a Certificate of Need. The physicians were advised by their legal counsel that private practitioners of medicine are specifically exempted from the provisions of Chapter 136, Public Law 1971, under Section 2 (b).

The Board of Trustees directed MSNJ's Legal Counsel to draft a letter to the Department of Health asking for an explanation of the difference between a health care facility and the private practice of medicine as it related to the case. Such a letter was sent in early October and no response has been received as of this date.

Subsequently, MSNJ learned that a Special Committee of the Health Care Administration Board was proposing the adoption of a regulation without qualification that would define "health care facility" as . . . "the practice of diagnostic radiology, therapeutic radiology, laboratory services, physical medicine and rehabilitation, and abortion services . . ." The Board of Trustees immediately joined in the filing of a minority report before the Health Care Administration Board protesting such a regulation.

While not formally presenting a rule in this regard, the Health Care Administration Board continued to maneuver and threaten medicine with just such a proposal. The Board of Trustees determined that the Society must utilize any and all methods available to it to oppose any regulation that would blanketly require physicians in private practice to acquire a Certificate of Need before opening or expanding an office.

At the March 17 meeting of the Board of Trustees, Dr. Dougherty, Acting Commissioner of Health, discussed some of the issues facing the Health Care Administration Board and The Medical Society of New Jersey. Your Board of Trustees empowered the Executive Committee of the Society to work with the Department of Health in a concerted effort to achieve reasonable and agreeable solutions to the many issues confronting medicine and government.

Hopefully, reason will prevail and sensible policy and programs will evolve.

Filed (page Tr 146)

Chronic Alcoholism
(Reference Committee "F")

At the AMA Clinical Convention, New Jersey introduced a resolution on "Chronic Alcoholism," as called for by MSNJ's House of Delegates last May.

The AMA adopted the resolution with the addition of a fourth resolved:

> "That insurance companies and prepayment plans be urged to remove unrealistic limitations on the extent of coverage afforded for the treatment of alcoholism, recognizing that alcoholism is an illness."

Filed (page Tr 146)

Equitable Composition of FDA Panel on Drug Evaluations
(Reference Committee "F")

Last year, the House of Delegates adopted resolution #22, which called upon MSNJ and the AMA to prevail upon the United States Food and Drug Administration to establish well-balanced panels consisting of practicing physicians and research-oriented physicians in regard to the evaluation of the efficacy and safety of all drugs and biologicals.

The Associate Commissioner for Medical Affairs of the Food and Drug Administration has replied in part . . .

"The resolution makes reference to a new 'federal administrative fiat' which mandates that FDA re-evaluate drug effectiveness. The review of drugs approved between 1938 and 1962 and the review of biologicals for effec-

tiveness is by legislative mandate and not by bureaucratic fiat. These studies stem directly from the requirements of the drug amendments of 1962.

"We note the concern of the Society regarding the competence of the individuals concerned with the evaluation of drugs and the recommendation that the agency should promote greater participation of practicing physicians.

"The Food and Drug Administration does, in fact, seek advice from the most capable and most experienced sources, including medical organizations, practicing physicians and specialists in specific fields. For example, it sought the judgment of the American Medical Association and the American Diabetes Association in regard to the possible cardiovascular hazard from long-term use of tolbutamide reported in 1970 by the University Group Diabetes Program. It has secured frequent advice from the Academy of Pediatrics in regard to many matters. It has collaborated from time to time with other specialty groups. It has appointed their leaders as members of advisory committees and as individual consultants. It has also invited them to submit nominations of other candidates.

"The staff of the FDA includes medical officers, most of whom have had years of experience in clinical practice. Most of them have also been certified as specialists in various fields. Internal judgments regarding drugs are thus contributed by knowledgeable physicians."

At the AMA Annual Meeting in June, the AMA House of Delegates adopted a resolution embodying the content of resolution #22 from The Medical Society of New Jersey.

Filed (page Tr 146)

Fitness for Licensure
(Reference Committee "F")

At the direction of the 1973 House of Delegates, MSNJ's Legal Counsel was instructed by the Board to investigate and clarify regulations and conditions under which a physician may be called for a hearing concerning his license to practice medicine and surgery in the State of New Jersey.

Legal Counsel reported:

"There are no statutes or rules governing procedures to be followed by the State Board as a prelude to determining whether disciplinary action should be instituted.

"When a case is brought to the attention of the State Board, it is thoroughly investigated.

"Once the State Board determines that there is substance to a complaint, the matter is referred to the Office of the Attorney General for the filing of a complaint and the scheduling of a hearing before the Board in accordance with the Administrative Procedure Act."

Filed (page Tr 146)

Hospital Readmission of Acute Cases
(Reference Committee "F")

The 1973 House of Delegates adopted resolution #10, as amended by Reference Committee "F," which called upon the Society's Medical-Hospital Liaison Committee to study the problem of readmission of patients from acute hospital facilities to nursing home facilities, where the continuity of care may be disrupted and, in some instances, never re-established with the initial admitting physician.

This resolution was discussed at the July 19, 1973 meeting of the Medical-Hospital Liaison Committee and was taken under advisement. It was decided that before action could be taken, the specifics of the problem would have to be thoroughly investigated.

Representatives of the New Jersey Hospital Association will take up the matter with the hospitals in the Essex County area.

Filed (page Tr 146)

Medicaid Waiver Project
(Reference Committee "F")

Following the 1973 Annual Meeting, a copy of substitute resolution #25 was sent to Robert L. Clifford, Commissioner, New Jersey De-

partment of Institutions and Agencies. His reply follows:

"The Board of Trustees has had the opportunity to review the resolution which you included with your letter and has addressed itself to the problem by the inclusion of representatives of additional groups on both the Task Force and the Board of Trustees.

"Shortly after the resolution was passed by your House of Delegates, the Board voted to reconstitute the Task Force which is charged with the drafting of a medical plan. In so doing, representatives of the North Jersey Medical Society, Essex County Medical Society, and others were included. It is this group which is charged with drafting and presenting to the Board the actual medical plan which will be submitted to the Department of Health, Education, and Welfare. That group will be meeting from time to time during the next month and will be in a position to consider the suggestions of interested parties. Suffice it to say that the Board agreed that additional information and assistance from medical groups was appropriate.

"Subsequently, the Board also voted to recommend that the Governor expand the Board by six members and the selection of those members will shortly be accomplished.

"Since the Task Force must consider alternatives and draft a proposed medical plan, it would appear that at this time the separate meeting involving the Departments of Health and Institutions and Agencies and the various groups, mentioned in your letter of June 6, would not be helpful."

Filed (page Tr 146)

Medicare Reimbursement Refusals
(Reference Committee "F")

Last May, the House adopted, as amended, resolution #17 (Medicare Reimbursement Refusals), which called upon MSNJ to seek to have the Prudential Insurance Company of America notify the patient of the exact reason for denial of a Medicare claim and to communicate its concern on this issue to the American Medical Association.

Contact was made with Prudential and the AMA and acceptable language was developed and is now in the process of implementation by the Social Security Administration.

Filed (page Tr 146)

School of Professional Psychology
(Reference Committee "F")

At the October meeting of the Board, it was learned that the Department of Higher Education was considering the establishment of a School of Professional Psychology with either the College of Medicine and Dentistry of New Jersey or Rutgers, The State University, serving as the administrative agent.

The Board adopted the position that the School of Professional Psychology should properly be located within the College of Medicine and Dentistry in order to assure appropriate and responsible relationships between all persons rendering personal health services to New Jersey citizens. Further, location within the College would, the Board felt, produce additional productive professional interrelationships for prospective degree candidates that would not be available at the State University.

The Board, therefore, authorized the issuance of a communication to the President of the College of Medicine and Dentistry of New Jersey indicating the Society's support in this regard.

Filed (page Tr 146)

Advisory Committee to the Office of Consumer Health Education
(Reference Committee "G")

Stanley S. Bergen, Jr., M.D., President of the College of Medicine and Dentistry of New Jersey, requested in January that MSNJ select a representative to serve on the Program's Advisory Committee for 1974.

The primary responsibility of the Advisory Committee is to advise the Program Director with respect to various program responsibilities including:

1. Development of a statewide regional network of hospital-based health education programs affiliated with the College of Medicine and Dentistry of New Jersey—Rutgers Medical School.

2. Research and development in techniques of personnel training, program development, management, financing, and evaluation of health education programs.

3. Development and operation of an information and resource center serving the state with health education materials, both printed and audio-visual.

Dr. Howard D. Slobodien was subsequently appointed to serve as MSNJ's official representative.

Filed (page Tr 149)

Better Protection of the Public from Food Handling Establishments Found Unsanitary
(Reference Committee "G")

At the 1973 Annual Meeting, the House of Delegates adopted a substitute resolution (#13) concerned with "Better Protection of the Public from Food Handling Establishments Found Unsanitary," a copy of which was sent to Commissioner of Health Cowan. Dr. Cowan replied as follows:

"We appreciate your Society's recognition of our 'commendable inspection efforts.' I must admit, however, to being somewhat puzzled by the suggestion to improve adequate publicity. Apparently, the author of the resolution is unaware that every disciplinary action is promptly reported to the media. Of course, there is no legal requirement that would compel the press to print our releases, but please be assured that a herculean effort is made to insure the widest possible dissemination of our activities."

Filed with comment (page Tr 149)

Dr. Howard Slobodien, Board of Trustees' Member

Supplemental Report

As the result of its April 21 meeting, the Board of Trustees directed several items to the attention of the 1974 House of Delegates. The Board therefore submits this supplemental report, which has been compiled since the preparation of its annual report.

Ad Hoc Committee to Investigate the Nominating Procedure
(Reference Committee "A")

At the 1973 Annual Meeting, the House adopted the report of the Ad Hoc Committee to Investigate the Nominating Procedure. That report called for component society secretaries to supply MSNJ with the names and completed informational data sheets on candidates for MSNJ elective offices from their county by March 31.

The Board of Trustees implemented the procedure and in early January notified all components of the elective offices to be filled. Also enclosed was a supply of the informational data sheets.

Thus far, response from the component societies has been virtually non-existent. As of this writing, only two counties have replied.

It is obvious, therefore, that the component societies as a rule have no interest in voluntary compliance and that the Secretary of MSNJ and Society staff are wasting their time and Society funds in attempting to effect the policy.

The Board, therefore, voted to discontinue the Nominating Procedure Policy adopted in May 1973.

Filed with comment (page Tr 138)

Liaison to the New Jersey Hospital Association
(Reference Committee "A")

For the first time The Medical Society of New Jersey has had physician representation at the monthly meetings of the Board of Trustees of

the New Jersey Hospital Association. Also, for the first time, a physician has been elected as a Regional Delegate to the American Hospital Association meetings. Doctor John S. Madara has served in both capacities this past year. Both the New Jersey Hospital Association and the American Hospial Association have made a definite effort to work in closer cooperation with physicians in policy making and in frank discussions of difficult problems which involve both physicians and hospitals.

As would be expected, there are still areas of disagreement. Among these are:

1. A definition of clinic facilities requiring a Certificate of Need—the New Jersey Hospital Association would like the Health Care Administration Board to have the authority to approve Certificates of Need for private medical facilities built by physicians.

2. The New Jersey Hospital Association opposes the rule of the State Board of Medical Examiners which requires the countersigning of chart orders and prescriptions written by unlicensed residents and interns.

3. It offers strong support to the New Jersey Utilization Program rather than the professional activities study favored by the New Jersey Foundation for Health Care Evaluation.

4. It opposes extending Rider "J" to cover physical therapy performed in the office of a duly registered physiotherapist.

5. It strongly supports the position of the House of Delegates of the American Hospital Association that the hospital administrator should be a voting member of the board of managers.

The areas of agreement between our two organizations are less newsworthy, but are evident of the continual day-to-day cooperation between physicians and hospitals.

Among the matters approved by both our groups are:

1. Opposition to the acupuncture bill, which regulates the practice of acupuncture, requires licensing of its practice, and creates a State Board of Acupuncture in the Division of Consumer Affairs.

2. Opposition to the mandatory requirement for testing of all new born infants for phenylketonuria.

3. Support of the bill requesting the Division of Motor Vehicles to provide space on New Jersey drivers' licenses for placing information concerning donation of organs.

4. Working together and conducting educational programs concerning battered children.

5. The recommendation that physicians actively practicing in the community who are members of the medical staff be accorded membership on the board of managers of health care institutions.

Over-all, there is a fresh wind blowing in both our organizations, and a feeling of mutual cooperation in making difficult decisions. The Cost of Living Council's price regulations on both hospitals and physicians has taught us the power of working together to achieve results beneficial to both of us. Doctor Madara feels confident that future cooperation between our two organizations can achieve even greater results.

Filed (page Tr 138)

Board of Trustees 1973-1974

Judicial Council

Albert F. Moriconi, M.D., Chairman, Trenton
(Reference Committee "A")

The Judicial Council has maintained its schedule of regular monthly meetings. From the official findings, the Council here presents a summary of its operations and those of county judicial committees for the period from May 14, 1973 through March 24, 1974.

By Judicial Committees

Complaints reported as disposed of 35

Alleging:
Dissatisfaction concerning fees 19
Unprofessional conduct 4
Dissatisfaction concerning medical procedures 4
Dissatisfaction concerning professional ethics 8

By the Judicial Council

Meetings held 7
Official communications acted upon 35
Appeal hearings requested 9
Appeal hearings granted 3
Formal opinions rendered 3

(1) Ethicality of several physicians purchasing an interest in an existing medical laboratory with the intent to direct their patients to the said laboratory for whatever tests that may be required.

(2) Ethicality of an ophthalmologist employing in his office an optician to sell or dispense glasses or contact lenses whereupon a portion of the profits would inure to the benefit of the physician in question.

(3) The Medical Society of New Jersey's *Principles of Medical Ethics* and a doctor's obligation to a Physician's Guild should he become a member.

The foregoing opinions are presented in full as an appendix to this report.

Regulations

The Council would at this time like to point out to the chairmen of the judicial committees of the component societies a primary cause of appeals during the past several years.

The *Rules and Regulations* of the Judicial Council provide that when efforts for amicable settlements of complaints have failed a hearing must be held, to which all parties are invited, before the complaint can be disposed of at the county level.

All too frequently the Council receives requests for appeal hearings wherein the record reveals that after settlement efforts have failed, the judicial committees reached a final decision without the benefit of a hearing. The Council has been constrained in these instances to refer these cases back to the judicial committee with the directive to hold a hearing.

The Council urges that each county committee strive to improve its procedure in this regard. Therefore, the committees are again reminded to follow the directions contained and the procedural steps outlined in the *Rules and Regulations for the Processing of Grievances and Complaints.*

Only by means of a full understanding and observance of the "Regulations" can the judicial committees together with the Judicial Council succeed in functioning at the level of adequacy intended by MSNJ's House of Delegates.

Referral from the 1973 House of Delegates Resolution #29—Investigation of "Medical Centers or Health Centers"

At the 1973 Fall Conference of Presidents and Presidents-Elect, the issue of "Store Front Health Facilities" in Passaic and Hudson was discussed at length.

The Chairman reported that the facilities in Hudson County had been closed by the State Board of Medical Examiners.

Opinion #1

Ethicality of Several Physicians Purchasing an Interest in an Existing Medical Laboratory with the Intent to Direct Their Patients to the Said Laboratory for Whatever Tests That May Be Required

This matter is controlled by Section 7 of the AMA *Principles of Medical Ethics* which states:

"In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies, or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient."

In this regard the Council takes note of Opinion #21 which states:

"Several proposals looking to the organization of groups of physicians in cooperative projects have been submitted to the Judicial Council. In most instances these have been in the nature of stock selling and stock holding schemes whereby physicians interested would realize on investments in proportion to the amount of work referred by them to the 'clinic' or laboratory operated under the particular scheme. After examination of these proposals, nearly all of them appear to be open to the criticism that they are, or may be suspected of being, essentially fee-splitting projects. The Council, therefore, has refused to give its approval to joint stock companies of physicians organized for the purpose of operating clinics or laboratories with the stock owned in part or in whole by physicians connected only as stockholders."

Additionally, the Council would like to place particular emphasis on Opinion #45 of the AMA *Principles of Medical Ethics* rendered under Section 7 which declares:

"To preclude the appearance of conflict of interest many physicians voluntarily limit their financial investments to fields completely unrelated to medicine or the health care industry. Even though strict interpretation of ethical principles does not require such limitation of one's financial investments that are otherwise in accord with ethical criteria, prudence and good judgment suggest that physicians should be most circumspect in their financial investments out of respect for the trust which their patients repose in them. The profession is better served when physicians avoid any appearance of compromise with the *Principles of Medical Ethics*."

Based upon the foregoing, the Judicial Council of The Medical Society of New Jersey believes that an arrangement such as that detailed above is not in the best interests of the patient nor within the tenor of the *Principles of Medical Ethics* and would be considered unethical.

Opinion #2

Ethicality of an Ophthalmologist Employing in His Office an Optician To Sell Or Dispense Glasses Or Contact Lenses Whereupon a Portion of the Profits Would Inure to the Benefit of the Physician in Question

One of the most important principles of medicine has been free choice of physician. This principle also applies to choice of optician and other types of practitioners.

The philosophy of the AMA in this regard is contained in Opinion #47 appearing under Section 7 of the *Principles of Medical Ethics.*

"Drugs, remedies, or appliances may be dispensed or supplied by the physician provided it is in the best interest of the patient." Under this language it cannot be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patient.

It is unethical for a physician to own stock in a pharmaceutical company which he can control or does control while actively engaged in the practice of medicine.

It is the opinion of the Judicial Council that this language was adopted to permit both the practicing physician and the local medical societies to evaluate the many factual situations incident to prescribing and dispensing which are bound to arise in the practice of medicine. Under this language the doctor is permitted to exercise his own best judgment when caring for his patients. It is known that there will be situations when it is necessary or desirable for a physician to dispense or supply what he has prescribed. The Principles permit this to be done.

On the other hand, this broad language provides a means by which a component society can inquire into the facts of a particular practice. The profession thus can act to prevent abuse of discretion and protect patients from exploitation. In essence this language means that a physician in the exercise of sound discretion may dispense "in the best interest of his patient;" it does not authorize him to dispense solely for his convenience or for the purpose of supplementing his income.

Since in the question presented, it is stated that the physician will profit from the services of the optician, the Council finds the practice not in the best interest of the patient, but a

plan to supplement the income of the physician and therefore, declares it unethical.

Returned to Council for reconsideration Tr 138

Opinion #3

The Medical Society of New Jersey's "Principles of Medical Ethics" and a Doctor's Obligation to a Physicians' Guild, Should He Become a Member

In general terms there should not, and basically, there must not be conflict concerning principles governing the ethical and professional conduct of a physician. Whether a member-physician is or is not a member of the Physician's Guild is immaterial since:

1. He must never abandon a patient still requiring continuing medical care.

2. He must never place personal, selfish, or financial interest above the ideals of the medical profession.

3. The ideals of the medical profession must be adhered to in any action taken by the guild physician, hence never changing his prime objective to render medical service to humanity and the patient.

4. These same ideals hold, should the guild physician ever reach the point in his actions in which he will cease or curtail his medical activities by making sure that at such times those patients needing medical care are carefully and appropriately instructed and directed to places or persons providing such medical care.

The Judicial Council of The Medical Society of New Jersey sees no conflict in the ethical and professional activities of members of the Guild provided the objectives referred to in the four preceding numbered paragraphs are scrupulously abided by and patients are never neglected when in need of medical attention.

Filed with notation on Opinion #2 (page Tr 138)

Incoming President Rogers accepts President's plaque from outgoing President Boylan.

Executive Director

Vincent A. Maressa, Trenton

(Reference Committee "A")

Society activity during the past administrative year has evidenced a marked, but thus far manageable, growth. The successes, stalemates, and frustrations of these endeavors will be more than adequately presented in the reports of the Board of Trustees and the various councils and committees.

The Executive Director attended a total of 105 MSNJ meetings. Additionally, as of this writing I made twelve visits to component societies, had fifty conferences and meetings with members of the Society, twenty-eight meetings with State and Federal Agencies on Society business, and attended three AMA meetings. The foregoing, of course, does not account for routine administrative office duties nor the large number of telephone discussions.

Traditionally, annual reports deal with past transactions and occurrences. With your indulgence I would like to depart from that format and offer some thoughts as to what the future may hold for medicine and how the ever-present challenges may be met.

On Constitution Avenue in Washington, D. C. stands the United States Department of Justice Building. Next to it is a structure housing the National Archives within which virtually every document and record reflecting the events, adventures, and misadventures of our country may be found. The cornerstone of the Archives Building is inscribed with the often-quoted phrase—"What is past is prologue." The truth of that statement being self-evident, medicine may anticipate a continued onslaught from ever-encroaching federal and state bureaucracies and sustained activity from certain non-governmental interests whose goals are to dominate and dictate the delivery of medical services.

Hopefully, these past events have crystalized the issues, identified the perpetrators, and elucidated the strategies and tactics medicine must employ if it is to assert and maintain a position as a free standing profession. We are firmly convinced that if medicine is to survive, it must patently project itself as a potent political, economic, and scientific force. To achieve this goal your Society must become truly vigorous, viable, and visible. It can no longer retreat, but must stand firm and then gradually, but steadily, regain the initiative. We are honestly convinced that given the support and direction of the House of Delegates and the Board of Trustees we will achieve a measured parity by the Spring of 1976, from which point on we hopefully may begin to reverse the losses suffered in the past thirty years, attributable to the crunch of advancing socialism and an energetic monolithic bureaucracy.

The opposition is formidable, well-seasoned, and possesses almost unlimited financial and staff resources. The task, however, does not present an insurmountable obstacle. Medicine can and will succeed if you want it to. You must be willing to participate actively in Society affairs. You must contribute more than monetary dues. You must be prepared to devote time and energy to the tasks before you. You should establish realistic priorities and pursue them with vigor. You should be more concerned with the present and the future than with the past. The House should be devoting itself to major objectives and stands rather than the strategies and tactics being utilized to gain the desired end.

One of the major failings of organized medicine is that for one reason or another it simply does not channel its resources to the areas where they can be truly effective. Things can and will change if you care enough to become involved and are willing to give of yourself. This Society can and will become truly responsive to your needs if you allow it to.

Filed (page Tr 138)

Standing Committees

Annual Meeting

Arthur Bernstein, M.D., Chairman, Maplewood

(Reference Committee "H")

The Committee met in June to formulate plans for the 208th Annual Meeting in accordance with directives of the 1973 House of Delegates and the Board of Trustees. It was noted that the 1973 annual report of the Committee on Annual Meeting was filed, with commendation to the Chairman of the Committee for the excellence of his report and for the accomplishments of his Committee throughout the year; the 1973 annual report of the Subcommittee on Scientific Exhibits was filed, with commendation to the Committee for their excellent selection of exhibits. A joint meeting with Officers of MSNJ's Scientific Sections and representatives of New Jersey specialty societies was held in September. A third meeting of the Committee was held in December.

The tentative daily schedule for the 1974 Annual Meeting was submitted to and approved by the Board. Subsequent to Board approval of the tentative daily schedule, details were worked out between Haddon Hall and the Convention Manager incorporating a package-deal weekend in conjunction with the 208th Annual Meeting, i.e., Carnival U.S.A. Weekend. Full details covering the Carnival U.S.A. Weekend were carried in the *Advance Program* which was mailed to the membership in February. It is hoped that, by including outstanding entertainment during the Annual Meeting, attendance will be greatly improved over 1973.

The final meeting of the 1973-1974 Board of Trustees will be held on Friday afternoon, May 10; and the reorganization meeting is scheduled for Tuesday afternoon, May 14, 1974. Both meetings will be held in the Bakewell Room.

The House of Delegates will meet in the Windsor Room at 2 p.m. on Saturday, at 3:15 p.m. on Sunday and Monday; and at 9 a.m. on Tuesday. Reference Committees "A," "B," "D," "G" and Constitution and Bylaws will meet at 3:00 p.m. on Saturday; "C," "E," "F" and "H" will meet at 10:00 a.m. on Sunday, The House will consider on Monday the reports of those reference committees that met on Saturday; and will consider on Tuesday the reference committee reports from Sunday's meetings.

The second (election) session of the House will be followed by the farewell message of the President and the inaugural address of the President-Elect.

The Board approved a recommendation of the Committee that the GMA Recipients and their families be invited (by the Chair) to attend the election session of the House and that they be seated by 3:15 p.m., thereby eliminating the delay between adjournment of the House and the GMA Ceremony. Thus, the 17th Annual GMA Ceremony will immediately follow the House adjournment, with a reception for award recipients and their families scheduled in the Derbyshire Room shortly thereafter.

The Nominating Committee will meet at 5 p.m., Saturday, May 11 in the Bakewell Room.

Official delegates will attend the 208th Annual Meeting from the Connecticut State Medical Society and the Medical Society of the State of New York. At the request of the President, the Chairman of the AMA Board of Trustees will also attend our meeting. Invitations were issued to the Editor of the American Medical News; and to the Presidents of the Medical Society of Delaware, the Medical and Chirurgical Faculty of the State of Maryland and the Pennsylvania Medical

Society to be guests of MSNJ. The Presidents of the Allied Associations (New Jersey State Bar Association, New Jersey Dental Association, New Jersey Hospital Association, New Jersey State Medical Assistants, New Jersey State Nurses' Association, New Jersey Association of Osteopathic Physicians and Surgeons, and the New Jersey Pharmaceutical Association) have again been invited to be guests of MSNJ at the annual dinner dance on Monday evening.

Registration will open in the Exhibit Hall at 9:30 a.m. on Saturday. All exhibits will be housed in the Exhibit Hall; exhibit hours will be from 12 noon to 5 p.m. on Saturday, and from 9 a.m. to 5 p.m. on Sunday and Monday. The Convention Offices will be located at the loading ramp end of the Exhibit Hall; and the Public Relations Center will occupy Room 134 on the first floor.

Roche Laboratories, Division of Hoffmann-LaRoche, Inc. will again sponsor the Motion Picture Theatre. A selection of up-to-date, informative and timely films will be shown in the Library, Lobby floor, on Saturday at 2 p.m. and on Sunday and Monday at 10 a.m. and 2 p.m.

The inaugural reception honoring President-Elect Rogers will be incorporated within the Carnival U.S.A. Weekend, and is scheduled for Sunday evening. The annual dinner dance honoring President Boylan will again be held on Monday evening. Admission to these two affairs, as well as to the Saturday evening dinner and entertainment, will be by tickets given by the hotel to all who register under the Carnival U.S.A. Weekend.

Jefferson Medical College Alumni Association will sponsor a reception on Sunday evening; and the Hahnemann Medical College Alumni Association will host a similar reception on Monday evening.

The Society for the Relief of Widows and Orphans of Medical Men of New Jersey will again hold its annual meeting on Sunday afternoon.

The Society is grateful to the Prudential Insurance Company of America for its continued cooperation in sponsoring the Coffee Lounge, and having representatives available to answer questions concerning Medicare in New Jersey. The American Association of Medical Assistants, State of New Jersey, will again staff the Message Center. The Coffee Lounge and Message Center will be located in the Exhibit Hall.

Invitations to prospective technical exhibitors were mailed early in December. The response was far from overwhelming; however, the following have contributed to the Educational Funds of MSNJ in lieu of exhibiting: Geigy Pharmaceuticals, Eli Lilly and Company, Mead Johnson Laboratories and Parke, Davis and Company. As in the past, these contributions will be used to help defray expenses in connection with the Scientific Sessions.

The 208th Annual Meeting will feature 39 technical exhibits, 29 scientific exhibits, and 12 informational exhibits. Admission to the Exhibit Hall and to the scientific sessions will be by badge only; therefore, everyone is strongly urged to register and to visit the exhibits and the scientific sessions of individual choice.

The *Advance Program,* prepared under the auspices of the Committee on Annual Meeting, was mailed in February to the membership, invited guests, non-member speakers and exhibitors, and editors of journals of nearby state medical societies—total 8,639. The April (Convention) issue of *The Journal* carried a detailed outline of the annual meeting, including abstracts of all scientific presentations and exhibit descriptions and room assignments. The *Official Program* will also carry full abstracts, as well as room assignments and hotel floor plans showing room locations.

In an effort to improve the structure of MSNJ's annual meetings, a meeting was held in October encompassing representation from pharmaceutical houses, hotel personnel, and MSNJ. A lively exchange of ideas and sugges-

tions resulted from this meeting, and it was generally felt that there is a need for greater cooperation between the medical industry and the medical profession. Complete details covering the October meeting, and subsequent actions taken, will be included in the annual report of the Council on Public Relations.

Last year the services of Secrephone were engaged for reporting the Special Session of the House of Delegates and also the 207th Annual Meeting. The transcripts were received promptly, were reasonably priced, and the copy was virtually perfect. Secrephone has again been engaged for reporting the 1974 Sessions of the House of Delegates and the dinner dance.

The Committee recommended, and the Board concurred, that SAMA representatives from the two New Jersey medical schools be again invited to attend the 208th Annual Meeting as observers, with expenses paid up to $150 per student.

The Director of the Division of Medical Assistance and Health Services, Mr. William J. Jones, together with Mr. Thomas Beatty, General Manager, Professional Relations Division, The Prudential Insurance Company of America, will participate in a Symposium on the Medicaid Program. This Symposium is scheduled for 1 p.m. on Monday in the Vernon Room, and will be moderated by your Chairman.

The House of Delegates has already approved the following annual meeting dates, which have been confirmed with Haddon Hall:

209th Annual Meeting—Saturday-Tuesday, May 10-13, 1975
210th Annual Meeting—Saturday-Tuesday, May 8-11, 1976
211th Annual Meeting—Saturday-Tuesday, May 7-10, 1977

Recommendation

That the 212th Annual Meeting of The Medical Society of New Jersey be held in Haddon Hall, Atlantic City, Saturday-Tuesday, May 13-16, 1978.

Approved—In conformity with Resolution #26, adopted by the House, MSNJ will negotiate with Haddon Hall to change dates to avoid conflict with "Mother's Day" weekend (page Tr 151)

Scientific Exhibits

John J. Thompson, M.D., Chairman, Caldwell

(Reference Committee "H")

Again this year, rather than schedule meetings, the members of the Committee were polled by mail. There were no changes made in the applications for Scientific and Informational Exhibits; nor were there changes made in the regulations governing these two categories of exhibits.

Applications for space in the 1974 Scientific Exhibits were mailed early in November to the following:

1. Department heads of Philadelphia, New Jersey, and New York City hospitals
2. Deans of Philadelphia, New Jersey, and New York City medical schools
3. 1974 Scientific Section Speakers
4. New Jersey State Departments of Health and of Institutions and Agencies
5. MSNJ Committee Chairmen

Letters were directed to editors of journals of nearby state societies requesting that they carry items in their publications calling attention to the 208th Annual Meeting of MSNJ; and inviting interested members of their societies to submit applications for space in the Scientific Exhibits.

Applications for space in the Informational Exhibits were mailed to State Departments, allied associations, and last year's exhibitors.

The *Membership Newsletter* carried items calling attention to and urging participation in the Scientific Exhibits. The November and December issues of *The Journal* of MSNJ included copies of the application and regulations governing exhibits.

Rather than schedule a mid-winter meeting, copies of all applications were mailed to the Committee for their review and separation into category—Scientific (Medical or Surgi-

cal), or Informational. Booth assignments were made in early January. As of this writing, there will be 29 Scientific Exhibits and 12 Informational Exhibits. Descriptive write-ups of all exhibits appeared in the April (Convention) issue of *The Journal.*

In accordance with previous policy, the Committee agreed to a minimum charge of $150 per ten feet of space occupied by Informational Exhibits—with the exception of those presented by Committees of MSNJ, the Society for the Relief of Widows and Orphans of Medical Men of New Jersey, the Academy of Medicine of New Jersey, and JEMPAC.

The Award plaques and certificates will be presented on the following basis: 1st and 2nd place Award plaques to New Jersey exhibitors; 1st and 2nd place Award plaques to out-of-state exhibitors; a special Award plaque from the Committee on Scientific Exhibits to a New Jersey exhibitor; and honorable mention certificates to New Jersey and out-of-state exhibitors.

As was done last year, the Award presentations will be made on Monday afternoon; and announcement of the winners will take place at the third session (Part I) of the House of Delegates.

Filed (page Tr 151)

Scientific Program

Arthur Bernstein, M.D., Chairman, Maplewood

(Reference Committee "H")

The Officers of the 1974 Scientific Sections met in September with the Committee on Annual Meeting, together with representatives of the New Jersey specialty societies. Because of the excellent cooperation of the section officers in sending to the Executive Offices their proposed programs by the due date, it was possible to cancel the meeting which was scheduled for October.

The President of the Neurological Association of New Jersey requested that a separate Section on Neurology be formed within the framework of MSNJ's scientific sections. The Board approved the recommendation that the Section on Neurosurgery and Neurology be separated into two sections—the Section on Neurosurgery and the Section on Neurology; and that the Neurological Association of New Jersey be added to the list of New Jersey specialty societies, with Eugene M. Pugatch, M.D., Secretary, listed as the official intermediary between that Association and MSNJ. The foregoing will be submitted to the 1974 House of Delegates for implementation.

Last year approval was granted to change the name of MSNJ's Section on General Practice to the Section on Family-General Practice, to conform with the change in title of the New Jersey Academy of Family Physicians. Subsequently, another request for further change in title was received—that MSNJ's Section be known in the future as the Section on Family Practice. This request was also approved and implemented.

In compliance with a recommendation that the Committee on Medical Education look into the possibility of presenting teaching courses on financial management for physicians, such courses to be scheduled early in the morning so as not to conflict with MSNJ's scientific sessions, two such courses will be scheduled during the 208th Annual Meeting. Two lectures on Problem Oriented Medical Records will be given at 8 a.m. on Sunday and Monday mornings. These lectures are to be sponsored by Health Management Systems, Inc.

The 1973 House of Delegates approved a recommendation of the Committee on Cancer Control that MSNJ allot some portion of its annual meeting to the problem of oncology: that the Committee on Cancer Control prepare and be responsible for the presentation to all New Jersey Medical Society members the following: (a) newest advances in cancer; and (b) report on statewide statistics. The Committee on Annual Meeting negotiated with the New Jersey Chapter, American

Cancer Society to present a scientific exhibit on Control of Cancer of the Uterine Corpus.

In furtherance of the accelerated medical education program proposed for the 208th Annual Meeting, the Board approved a recommendation of the Committee that space be made available at no charge to Roche Laboratories, ROCOM Division, for a display of their refresher courses. This will receive continuing medical education accreditation.

The Scientific Program Committee is pleased to announce that there will be a Cardiac Pulmonary Resuscitation program, sponsored by the American Heart Association, New Jersey Affiliate, at the 208th Annual Meeting. This medical education program will be extensive and will include films, lectures, and mannequin displays.

The Board approved a recommendation of the Audit Committee that the Committee on Annual Meeting be requested to look into the possibility of considering more than one location for registration, and if feasible, that registration be available at each scientific session. The Committee agreed that two registration locations would not be practical or feasible; however, it should be noted that, with the approval of hour-for-hour accreditation of all of MSNJ's scientific sessions, registration will be available at each of the sessions.

With the addition of two new sections—Section on Physical Medicine and Rehabilitation and Section on Emergency Medicine—MSNJ now numbers 23 Scientific Sections. It should be noted that in 1974 the Section on Obstetrics and Gynecology will conduct a business meeting rather than a scientific session program; also, the Section on Clinical Pathology will not participate in the 1974 Scientific Sessions.

Increased attendance figures from the 1973 Scientific Sessions bore out the Committee's consensus that co-sponsorship by New Jersey specialty societies has greatly enhanced our annual meeting. Again this year, all but one of the 15 Scientific Sessions will be co-sponsored by one or more New Jersey specialty societies. The following schedule has been set up for the 1974 Scientific Sessions:

Sunday, May 12—a.m.

Session on Emergency Medicine—co-sponsored by New Jersey Chapter, American College of Emergency Physicians
Joint Session on Cardiovascular Diseases, Family Practice, Medicine—co-sponsored by New Jersey Society of Internal Medicine and the American College of Physicians
Joint Session on Radiology, Urology

Sunday, May 12—p.m.

Joint Session on Anesthesiology, Ophthalmology, Otolaryngology—co-sponsored by New Jersey State Society of Anesthesiologists and the New Jersey Academy of Ophthalmology and Otolaryngology
Session on Family Practice—co-sponsored by New Jersey Academy of Family Physicians
Joint Session on Medicine, Rheumatism—co-sponsored by New Jersey Society of Internal Medicine and the New Jersey Rheumatism Association
Session on Neurosurgery and Neurology—co-sponsored by New Jersey Neurosurgical Society and the Neurological Association of New Jersey
Session on Psychiatry—co-sponsored by New Jersey Psychiatric Association and the New Jersey Psychoanalytic Society

Monday, May 13—a.m.

Session on Dermatology—co-sponsored by the New Jersey Dermatological Society
Session on Surgery—co-sponsored by the Academy of Medicine of New Jersey, the New Jersey Chapter, American College of Surgeons, the College of Medicine and Dentistry of New Jersey-Rutgers Medical School, Piscataway, the New Jersey Medical School, Newark, and MSNJ's Section on Gastroenterology
Joint Session on Allergy, Chest Diseases, Family Practice, Medicine—co-sponsored by the New Jersey Allergy Society, the American College of Physicians, and the New Jersey Academy of Family Physicians
Session on Orthopaedic Surgery—co-sponsored by the New Jersey Orthopaedic Society
Session on Physical Medicine and Rehabilitation—co-sponsored by the New Jersey Society of Physical Medicine and Rehabilitation

Monday, May 13—p.m.

Session on Gastroenterology and Proctology—co-sponsored by the New Jersey Gastroenterological Society and the New Jersey Proctologic Society
Joint Session on Pediatrics, Plastic and Reconstructive Surgery—co-sponsored by the New Jersey Chapter, American Academy of Pediatrics and the New Jersey Society of Plastic and Reconstructive Surgeons

Your Committee is pleased to announce that through the Academy of Medicine of New Jersey, hour-for-hour credit for *all* of the 1974 MSNJ scientific sessions has been approved for Category I, AMA Physician's Recognition Award, Continuing Medical Education Pro-

gram, MSNJ; and the three sessions being sponsored by MSNJ's Section on Family Practice have been approved for two hours of prescribed credits by the American Academy of Family Physicians.

The following luncheons have been scheduled in conjunction with the 1974 Scientific Sessions:

- New Jersey Allergy Society
- New Jersey State Society of Anesthesiologists, Inc.
- New Jersey Chapter, American College of Chest Physicians (annual Selman A. Waksman Lecture)
- New Jersey Dermatological Society
- New Jersey Chapter, American College of Emergency Physicians
- Section on Neurosurgery and Neurology
- New Jersey Academy of Ophthalmology and Otolaryngology
- New Jersey Orthopaedic Society
- New Jersey Society of Physical Medicine and Rehabilitation
- New Jersey Committee on Trauma, American College of Surgeons
- New Jersey Medical Women's Association

It should be noted that in the future, the Annual Trauma Oration of the New Jersey Chapter, American College of Surgeons will be identified as the "Spencer T. Snedecor Trauma Oration."

A total of 55 outstanding member- and guest-speakers will participate in the 1974 Scientific Sessions.

Last Year MSNJ initiated a policy whereby guest-speakers would receive $100 honoraria, in addition to the already-established policy of payment for overnight hotel accommodations, meals, gratuities, and travel expenses to and from Atlantic City. Honoraria for 26 guest-speakers in 1973 amounted to $2,600.00. This year, of the 55 speakers only 23 are non-members of MSNJ.

Filed (page Tr 151)

President Boylan — Board Chairman Marchione — President-Elect Rogers

Credentials

Louis F. Albright, M.D., Chairman, Spring Lake
(Reference Committee "A")

The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The following statistical breakdown reflects the committee's activities during the period March 1, 1973 to February 28, 1974.

	Associate 3/1/73 to 5/31/73	*Active by Advancement 3/1/73 to 5/31/73*	*Active 3/1/73 to 5/31/73*	*Active 6/1/73 to 2/28/74*	*Total*
Received	92	44	46	519	701
Reviewed and found:					
Satisfactory	92	44	46	461	643
Unsatisfactory	0	0	0	0	0
Pending	0	0	0	58	58
Total	92	44	46	519	701

The Committee extends appreciation to the secretaries of component societies, and to those who assist them, for their cooperation in processing membership applications. It would be especially helpful to the Credentials Committee of MSNJ if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application form. This procedure will help insure more accurate and speedy evaluation of credentials.

Filed (page Tr 139)

1973 TRANSACTIONS

At its first session on Saturday, May 11, 1974, the House of Delegates approved the Transactions of the 1973 House of Delegates as published in the July 1973 issue of THE JOURNAL and distributed to the membership.

Honorary Membership

Ralph M. L. Buchanan, M.D., Chairman, Phillipsburg
(Reference Committee "H")

No nominations were submitted this year to the Committee. Consequently, no meetings were held during this administrative year.

Filed (page Tr 151)

Finance and Budget

Nicholas E. Marchione, M.D., Chairman, Vineland
(Reference Committee "B")

A review of the expenses of the first ten months of the current administrative (fiscal) year and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

The Journal and Annual Meeting Expense

The (net) *Journal* Deficit is anticipated to be higher, even though this will be the second year that a per capita assessment designated for each member's *Journal* subscription rate will be applied. Your Committee recommended, with the concurrence of the Board of Trustees that the yearly subscription rate be increased from $7 to $10 retroactive to January 1, 1974. The approval of this increase allows the dues' allocation to the *Journal* to be raised from $3.50 to $5 per member retroactive to January 1, 1974.

The foregoing action was taken to offset the anticipated increase in the net deficit which can be attributed to several factors: (1) reduced volume of national advertising supplied by SMJAB, due in part to the strict disclosure demands of FDA and the failure of pharmaceutical manufacturers to increase advertising budgets despite rising costs and the appearance of new medical publications on the market, while local advertising income was up slightly, the net result reflects a decrease of approximately 3.5 percent; (2) an over-all increase in costs of 30.2 percent of which publication expense accounts for 6.2 percent and non-printing costs accounts for 24 percent centering on additional personnel, salaries, taxes, commissions, office expenses, and insurance; (3) the effects of the new rate structure reflecting 15 percent increase for full and for one-half page advertisements, although effective with all new contracts, January 1, 1973, when contracts were renewed, did not yield the anticipated impact because of reduced advertising space sales. The experience in 1974 has been consistent for all state journals, the group associated with as well as not associated with the State Medical Journal Advertising Bureau. However, it is felt that the printer has rendered another satisfactory year in printing *The Journal.*

Your Committee recommended, with the concurrence of the Board of Trustees, that the 1975 assessment include a $5 and $2.50 per capita assessment designated for each member's *Journal* subscription rate, and Annual Meeting registration rate, that the full amount realized as of May 31 be applied in 1975, and that the Committee on Finance and Budget be called upon to review these allocations annually.

Your Committee was cognizant of the fact that the above action will not completely discharge the deficits incurred each year in these two accounts. Nevertheless, the net deficit in each account will be considerably less and will readily be charged to the unexpended balance of the fiscal budget.

Emergency Medical Care and the Inter-Agency Commission on Emergency Medical Care

Your Committee has approved, with the concurrence of the Board of Trustees, the inclusion of $7,500 in the budget of the Committee on Emergency Medical Care for 1974-75 for the Inter-Agency Commission on Emergency Medical Care and that every effort be made on the part of the Inter-Agency Commission to encourage other participating agencies to contribute to the support of this agency as well.

Medical Education and The New Jersey Academy of Medicine

Your Committee has approved, with the concurrence of the Board of Trustees, the inclusion of $25,000 in the budget of the Committee on Medical Education for 1974-75 for the

Academy of Medicine of New Jersey for postgraduate educational programs and activities, with the proviso that the Committee on Medical Education, with the concurrence of the Board of Trustees, be empowered to expend up to this amount in the course of the administrative (fiscal) year on the basis of need reflected in the 1974-75 fiscal report to be submitted by the Academy of Medicine to the Committee on Finance and Budget.

New Jersey Foundation for Health Care Evaluation

Your Committee has approved, with the concurrence of the Board of Trustees, the proposed 1974-75 budget prepared by the Finance Committee of the New Jersey Foundation for Health Care Evaluation. The budget totals $83,194.

1975 Assessment

The computation of unappropriated General Fund balance at the close of the current fiscal year is estimated at $190,545.76—8.9 percent above the $175,000 sum approved, with the concurrence of the Board of Trustees, as the desired minimal surplus.

In accordance with Chapter X of the Bylaws, the dues year is January 1 to December 31, and the fiscal year is June 1 to May 31. The administrative year including the budget, which controls expenditures, is based on the fiscal year. It therefore becomes necessary to apportion the 1974 and 1975 per capita assessment to the 1974-75 fiscal year on the basis of 7/12 of the 1974 assessment for the new fiscal year soon to commence (June 1, 1974), and 5/12 of the 1975 assessment for the latter part of that fiscal year starting January 1, 1975.

The following is the Computation of the Cash Surplus and the Determination of the 1975 Assessment: (Unappropriated General Fund Balance)

Proposed budget for 1974-75	$609,872.00
7/12 of 1974 assessment applicable to 1974-75 budget	$347,712.00
Amount to be raised by 5/12 of 1975 assessment	$262,160.00
$87.24 × 7,212 members paid = $629,174.88 × 5/12	$262,156.20
Amount to be raised with surplus over $150,000 applied to budget excess at 5/31/74, estimated	$ none
Amount needed to reduce the per capita assessment from $—— to $——	$ none
Remainder of surplus in excess of $150,000	$ 15,595.76
Add the required surplus	$175,000.00
Estimated adjusted cash surplus at 5/31/74	$190,545.76
$90.00 × 7,212 members paid = $649,080 × 5/12	$270,450.00
plus the amount raised from surplus	$ none
Amount to be raised to meet 5/12 requirement	$262,160.00
Estimated excess raised to meet 5/12 requirement	$ 8,290.00

For each $1,000 increase in the proposed budget add .33¢ to assessment.

For each $1,000 decrease in the proposed budget subtract .33¢ from the assessment.

1974-75 Budget

The proposed budget for 1974-75 totals $609,872. It is the opinion of the Committee that the budget should adequately provide the necessary funds for the efficient operation of the Society's business during the coming year. It is not to be assumed that all sums budgeted will necessarily be utilized.

As requested by the House of Delegates, your Committee is listing explanatory footnotes on accounts which show a marked difference between current and proposed budgets.

Your Committee has included as an attachment the 1974 dues assessment for the fifty-one State Societies.

Recommendations

(1) That the budget for 1974-75 be adopted in the total sum of $609,872.

Approved (page Tr 140)

(2) That the 1975 assessment be adopted at $90 per capita, with no provision for a contribution to AMA-ERF. The dues assessment will cover a budget allocation, for the sixth consecutive year, to the Academy of Medicine of New Jersey which eliminates the need for a special assessment therefor. The dues assessment will also cover a budget allocation, for the first time, to the Inter-Agency Commission on Emergency Medical Care. Of the $90 per capita assessment, $5 and $2.50 are designated respectively for the member's *Journal* subscription and Annual Meeting registration, and the full amounts realized as of May 31, will be applied in 1975.

Approved (page Tr 140)

(3) That a special assessment be adopted at $10 per capita, to serve as a grant to the New Jersey Foundation for Health Care Evaluation; that this special per capita assessment be set in addition to, and not as part of, the budgetary assessment; and that both be paid at the same time.

Approved with the following additional recommendation from the Reference Committee (page Tr 141):

That The Medical Society of New Jersey re-examine and re-evaluate the function of the New Jersey Foundation for Health Care Evaluation and its relationship to The Medical Society of New Jersey

(4) That the 1975 assessment be set at $20 per capita for affiliate and associate members as it was for 1974.

Approved (page Tr 140)

Account	Current Budget 1973-74	Foot-notes	Proposed Budget 1974-75
A— 1—Executive Salaries	$ 74,523.00	(1)	$ 98,485.50
A— 2—General Staff Salaries	166,301.59	(1)	192,882.75
A— 3—Gen. Exec. Office Expenses	22,500.00	(2)	27,000.00
A— 4—Executive Travel	6,900.00		4,700.00
A— 5—House Maintenance	31,100.00		30,500.00
A— 6—Treasurer	8,000.00	(3)	8,400.00
A— 7—Finance & Budget	75.00		75.00
A— 8—Secretary	400.00		400.00
A— 9—Salary Taxes	17,089.41		17,128.75
A—10—Insurance	12,300.00	(4)	14,000.00
A—11—House Reserve	12,200.00		10,000.00
A—12—MSNJ Pension Plan	1,700.00	(5)	2,200.00
A—13—MSNJ Building Loan	13,500.00	(6)	14,100.00
C— 2—Legislation	9,200.00		8,500.00
C— 3—Public Health	2,700.00	(7)	3,300.00
C— 4—Public Relations	46,000.00	(8)	37,000.00
C— 5—Medical Services	700.00		750.00
C— 6—Mental Health	1,600.00		1,700.00
D— 1—President-Pres. Officers	15,600.00	(9)	16,300.00
D— 2—AMA Delegates	15,000.00	(9)	19,320.00
D— 3—Woman's Auxiliary	5,600.00	(9)	6,680.00
D— 4—Medical Education	35,300.00	(10)	30,500.00
D— 5—Conference Groups	500.00		500.00
D— 6—Membership Directory	16,000.00	(11)	21,600.00
D— 7—Emergency Medical Care	300.00	(12)	7,900.00
D— 8—Credentials	1,000.00		1,200.00
D— 9—Archives & History	100.00	(13)	———
D—10—Project Hope-Vietnam	6,000.00	(13)	———
D—11—Med. Def. & Insurance	500.00		700.00
D—12—Mem. Inq. & Complaint	1,000.00		1,000.00
E— 1—Board of Trustees	7,500.00	(14)	8,500.00
E— 2—Contingent	10,000.00		10,000.00
E— 3—Judicial Council	500.00		500.00
E— 4—Legal	7,300.00		3,550.00
E— 6—Medical Student Loan Fund	6,000.00		6,000.00
E— 7—Authorized Reimbursement for Representatives to Meetings	4,000.00	(14)	4,500.00
TOTALS	$558,989.00		$609,872.00

(1) Increase due to increments granted to both executive and general personnel.

(2) Increased to cover higher luncheon cost and preventive maintenance agreements charged to this account.

(3) Increased to cover higher expenses anticipated in bookkeeping and accounting services.

(4) Increased to cover higher expenses anticipated under the insurance programs for the staff and the Executive Offices of The Medical Society of New Jersey.

(5) Increased to cover higher expenses anticipated under the insurance program provided to participants in MSNJ's Pension Plan.

(6) Increased to cover higher interest expense anticipated on MSNJ's building loan.

(7) Increased to cover higher specific expenses anticipated on MSNJ's annual Eye Health Screening Program.

(8) The Committee wishes to point out that although this account shows an overall reduction of $9,000.00, in reality there is an increase of $11,000.00 in usable Public Relations monies, because effective June 1, 1974 Public Relation salaries will appear in the Salary Account.

(9) Increased to cover higher anticipated expenses in attendance at the AMA Annual and Clinical Conventions.

(10) The Medical Education Committee, with the concurrence of the Board of Trustees, is empowered to expend up to $25,000.00 in the course of the administrative year (1974-75) to the Academy of Medicine of New Jersey for postgraduate educational programs and activities, on the basis of need reflected in the fiscal report to be submitted by the Academy to the Committee on Finance and Budget.

(11) Increased to cover higher anticipated expenses associated with the publication of the 1974-75 edition of the *Membership Directory*.

(12) Increased to cover the inclusion in the budget of the Committee on Emergency Medical Care for 1974-75, $7,500.00 earmarked for the Inter-Agency Commission on Emergency Medical Care.

(13) Account has been retired effective June 1, 1974 because of no activity.

(14) Increased to cover higher anticipated expenses.

Filed as amended (page Tr 140)

State Societies Dues for the Year 1974

Below are the fifty-one State Societies in the order from the highest dues assessment down to the lowest:

1.	Nevada	$260
2.	Alaska	250
3.	Dist. of Columbia	220
4.	Hawaii	205
5.	Montana	200
6.	Iowa	200
7.	Utah	165
8.	Colorado	150
9.	Idaho	150
10.	Wisconsin	145
11.	North Carolina	145
12.	Delaware	140
13.	Michigan	135
14.	California	135
15.	New Mexico	135
16.	Illinois	130
17.	Kentucky	130
18.	Minnesota	125
19.	Maine	125
20.	Alabama	125
21.	South Dakota	125
22.	Wyoming	125
23.	Arkansas	125
24.	Kansas	125
25.	North Dakota	125
26.	Washington	122
27.	Arizona	120
28.	Indiana	120
29.	Oklahoma	120
30.	New Hampshire	120
31.	South Carolina	120
32.	Oregon	115
33.	Maryland	110
34.	New York	100
35.	Georgia	100
36.	Mississippi	100
37.	Nebraska	100
38.	Pennsylvania	100
39.	Rhode Island	100
40.	West Virginia	100
41.	Vermont	100
42.	**New Jersey**	**90**
43.	Louisiana	85
44.	Massachusetts	85
45.	Virginia	85
46.	Texas	80
47.	Tennessee	80
48.	Florida	75
49.	Missouri	75
50.	Connecticut	75
51.	Ohio	65

House of Delegates

Medical Defense and Insurance

Paul J. Kreutz, M.D., Chairman, Elizabeth

(Reference Committee "C")

In 1973 we implemented many additions and expansions to our insurance programs which the Society had previously endorsed for the benefit of its members. Two new programs were added and three existing programs were expanded. The two new programs were the EPIC Automobile Insurance Program providing low cost automobile insurance for members and their employees and the new Professional Overhead Expense Plan which has very high limits and attractive rates, especially for the younger members.

Our Life Insurance Program was increased $100,000 so that it now provides a maximum of $250,000 of coverage. Our Hospital Money Program was expanded to $50 and $60 a day. Our Accident and Health Program was expanded so that now the entire program is $3,600 a month and can all be under the Long Term Plan providing accident benefits for life and sickness coverage to age 65.

Details of all the plans, including the new and improved ones, follow:

Accident and Health Insurance

The Society's Accident and Health insurance programs are administered by the E. & W. Blanksteen Agency, Inc., who have just completed their 44th year of service to our members. This comprehensive disability income program now affords a monthly benefit up to $3,600 a month during total disability due to injury or sickness. Last year, the limits of coverage available were increased to $3,600 to fill the need of members for more adequate amounts of disability insurance in low-cost Society plans. The program consists of two parts: The Basic Extended Plan and the Long Term Plan. The plans differ primarily in the length of time benefits are payable. For an accident disability, the Basic Plan pays up to five years; the Basic-Extended plan up to lifetime; and the Long Term plan up to lifetime. For a sickness disability, the Basic Plan pays up to two years; the Basic-Extended plan up to seven years; and the Long Term plan up to age 65. Both the Basic-Extended Plan and the Long Term Plan are underwritten by the Nationwide Mutual Insurance Company. Members may carry up to $3,600 of which up to $1,200 may be in the Basic-Extended Plan. Up to three policies are issuable to any member for maximum flexibility. The Company will rearrange policies and existing coverage to accommodate changing needs within the 3-policy limit.

Basic-Extended Plan

The Basic disability plan provides as much as $1,200 monthly benefit with the Nationwide Mutual Insurance Company. Benefits are payable from the first day of accident total disability for as long as five years and the eighth day of sickness total disability for as long as two years. Waiting periods of 30 or 60 days are available to provide reduced premiums for those whose circumstances make desirable a plan whose benefits could begin on a later date than 1st day accident and 8th day sickness. The plan also pays, at half the monthly benefit rate, from the first day of accident partial disability for as long as six months. The plan also includes accidental death and dismemberment benefits. By adding the Extended plan, accident total disability benefits may be extended to lifetime, and sickness total disability benefits may be extended for an additional five years, or a total of seven years altogether. There are 5499 basic policies covering our members with some members having two basic policies. It is the Administrator's practice to combine two basic policies into one whenever members revise or increase their insurance programs so as to simplify the record-keeping and billing procedures.

Long-Term Professional Income Protection Plan

Members may now carry to $3,600 under this

plan less the amount carried under the Basic-Extended Plan. Benefits are payable for lifetime for accident total disability and to age 65 for sickness total disability. One of the chief purposes of this plan is to provide both accident and sickness disability benefits to the age where other financial arrangements begin to fall into place; such as annuities, life insurance settlement options, and social security. The plan also affords six months of partial disability at half the monthly benefit rate. Benefits may begin from the 31st, 61st, 91st or 181st day of disability, with appropriate reductions in premium. Currently 1413 members participate in this program which began in 1965.

It is possible for a member to have the various disability plans in almost any combination of monthly benefit and plan to fit personal requirements. The ideal goal for most doctors is to insure about two-thirds of monthly gross income. More monthly benefit than this is unnecessary inasmuch as all benefits are tax-free for Federal Income Tax purposes. Members who apply for the Basic-Extended Plan within their new member periods are issued coverage, within certain limits, without regard to medical history.

All of our accident and health policies have the guaranteed Conversion Provision Rider. Briefly, this rider provides that if Nationwide were unilaterally to terminate any of its accident and health insurance programs for members of the Society, the Company is committed to issue a guaranteed renewable policy for the same benefits as those provided each insured member under the Society's program.

Major Expense Plan

Our Major Expense Plan was revised and improved in 1970 and now provides a maximum benefit for each accident or sickness of $25,000 with members of Medicare age covered up to $7,500 in addition to Medicare benefits. The room and board rate is $100 daily for intensive care and $50 for all other accommodations. The private duty nursing benefit now takes into account $24 for each eight-hour shift in the hospital. On a three-shift day, a maximum of $72 can be paid for nursing coverage. The deductible amount is $750 for each benefit period. There is *no* coordination-of-benefits provision for those below Medicare age!

The program now covers 2500 members with many members including coverage for their wives and children. New members to the Society may obtain coverage under the Major Expense Plan without regard to medical history provided they apply within their allotted two-month new-member period. E. & W. Blanksteen Agency, Inc., administers this plan.

Hospital-Money Plan

Our Hospital-Money Policy, administered by E. & W. Blanksteen Agency, Inc. provides $20, $30, $40, $50 or $60 a day for each day of hospital confinement up to a maximum of 365 days for any one confinement. It can cover member, spouse and dependent children. New members are able to obtain this program non-selectively as part of their new-member privilege, 352 members participate in this program.

EPIC Automobile Insurance Program

The Society has adopted the EPIC Automobile Program of the Automobile Insurance Company of Hartford—administered by E. & W. Blanksteen—as a solution to the problem many members had of having high automobile insurance premiums and the inability of some of our members to obtain adequate coverage at any price. We are the first medical society in the country to offer this low-cost guaranteed issue automobile insurance plan to its members and their employees. The EPIC Plan has the following characteristics:

Four out of five applicants will save 5 to 15 percent (and in some cases up to 40 percent) of their present insurance cost.

One out of five may pay more (because of driving record, and so on) but will get full coverage.

Five out of five members who hold a valid driver's license and participate in the Authorized Check Plan will be guaranteed a policy that they will have the sole option of accepting.

The key part of the program is the direct servicing of claims by company claim offices and the convenient Authorized Check Plan whereby premiums are automatically deducted monthly (without extra charge!) from your checking account. Up to $1,000,000 bodily injury and property damage coverage is available with all the other important coverages available at your option. No-Fault reductions and special No-Fault coverage are, of course, provided under the Plan.

Some of the savings members have received under the Plan are impressive and we would certainly urge members to obtain a no-obligation quotation from our administrator to see whether or not they are one of the ones who can participate in the large savings available.

Since the last annual meeting, the Committee and the administrator have searched for possible alternate carriers providing similar coverage for our members and we wish to report that no such alternate program appears to be available. Our EPIC Automobile Insurance Program is currently unmatched for the features it offers our members and the premium rate structure it provides.

Overhead Expense Program

Many of our members find their overhead expenses quite high with the increase in employees' salaries, rentals, and other necessary expenses pertaining to their practice of medicine. Overhead Expense coverage has now become necessary in the Society-sponsored program and they have sponsored an excellent program through the National Casualty Company administered by E. & W. Blanksteen Agency, Inc. that provides up to $2,500 monthly benefit beginning with the 31st day of total disability and lasting as long as two full years.

This program will be offered in a special non-selective enrollment and if, during this enrollment, 1500 of our members under the age of 60 apply, they will be guaranteed issuance of at least $500 monthly benefit provided only that they are members of the Society in the full-time active practice of medicine and are under age 60 at the time the policy is issued. At the end of last year, 202 applications toward the quota had been received from the pre-enrollment announcement.

In accordance with IRS regulations, the premiums under this program are considered a business expense and are tax-deductible.

Life Insurance—Nationwide Life Insurance Company and Bankers Life Company of Des Moines, Iowa

The maximum coverage under our Life Plan was increased to $250,000 by the addition of the $100,000 maximum coverage Bankers Life Plan in addition to the $150,000 program of the Nationwide Life Insurance Company that has been in effect for many years. During the month of May members received information concerning this new and additional program which made available more insurance at lower cost to our members. Of our members, 52 applied for and were issued $1,660,000 of insurance protection under this new plan.

Our original Nationwide Life Insurance Program includes not only the member but also his spouse and dependent children (between the ages of 15 and 21, or up to age 26 if a college student) and employees. An important feature of this expansion is that each person will have his own Five Year Renewable and Convertible Term Policy and it is not necessary for the member to take out insurance for himself in order to provide coverage for a member of his family or an employee. This added feature enables the life insurance program to serve many more needs of our members especially those who wish to provide benefit programs for their employees. The administrators are E. & W. Blanksteen Agency, Inc.

The life program provides each insured person with a Five Year Renewable and Convertible Term Policy with a guaranteed conversion on a non-medical basis to permanent life insurance at any time. The program now pro-

vides up to $150,000 of coverage for members and up to $50,000 of coverage for spouse, dependent children, and employees. All coverage is issued in the form of convenient units of $10,000 with Waiver of Premium and Double Indemnity for accidental death included without premium charge. Since inception of the program, there have been 256 death claims in which a total of $2,645,000 was paid out.

Through the large volume of insurance and strong participation of our members in this program we are able to have non-cancellable term life insurance at a very low cost. At the present time, over 1800 of our members participate in the program with approximately $29,755,000 of insurance currently in force. This plan is also available to spouses, children and employees and 100 of them participate in this program.

The additional $100,000 coverage through the Bankers Life Company is available to members whether or not they carry insurance under the original program. This will make possible larger amounts of insurance without the necessity of a physical examination and gives our members even greater flexibility in establishing their insurance program. The net cost and structure of the Bankers Life Program is quite similar to that of the Nationwide Life Insurance Company described above.

Six Point, High-Limit Accident Insurance Plan

Our Six Point, High-Limit Accident Insurance Plan with the Nationwide Mutual Insurance Company, administered by E. & W. Blanksteen Agency, Inc., provides up to $200,000 for accidental death benefit with dismemberment benefit, loss of sight, exposure, disappearance and even a total disability feature, at less than the usual cost of the accidental death benefit alone.

Special spouse coverage is available under this policy at very low cost; 786 of our members participate in this program.

Professional Corporations

E. & W. Blanksteen Agency, Inc., our administrator for the Basic-Extended Long Term Professional Income Protection Plan, Major Expense Plan, Hospital Money Plan, Six-Point High-Limit Accident Insurance Plan, EPIC Automobile Insurance Plan, Overhead Expense Plan and Life Insurance Plan, has advised that all the programs are adaptable for use in professional corporations with necessary assignment forms available upon request.

Recommendation

That the E. & W. Blanksteen Agency, Inc., be continued as the official broker for MSNJ's Accident and Health, Major Expense, Hospital-Money, Life, High-Limit Accident, Automobile Insurance, and Professional Overhead Expense Programs.

Approved (page Tr 142)

Professional Liability Program

The Committee met during the past year and considered changes taking place within the practice of medicine which may effect professional liability, new concepts in insurance, plus administration of programs currently in existence.

The *1973 rate increase,* approved by the Committee, Board of Trustees and House of Delegates, provided for varying allocations of the additional premium among the major classes of practice. Following a study by the New Jersey Department of Insurance, complicated and delayed by the introduction of Phase IV guidelines, it was recommended that the increase should be spread equally among the five major classes, except that higher rates would be applied to two major surgical practices and a small increase applied to a sixth class. Following a meeting between Society representatives and the insurance commissioner, the new rates were approved by the New Jersey Department of Insurance and Federal Cost of Living Council as of October 1, 1973. The final result was within the *overall* percentage previously approved by the Society.

Incidentally, there was no increase in rates for our approved professional liability "umbrella" coverage in 1973 nor will there be an increase in 1974.

Control of losses continues to be a basic element in our program and several activities were conducted as follows:

(1) A joint meeting was held with the Chairmen of County Medical Review and Advisory Committees, which involved the following:

. . . An analysis of the current attitude of the three insurance companies who have participated in the program since 1960;

. . . An in-depth review of our medical review and advisory program;

. . . A discussion of desirable changes to provide for more effective participation and results.

(2) It was decided at the above meeting to remind each member of the availability of Medical Review and Advisory Committees for the purpose of reviewing claims made against them. This is particularly applicable if the insurance company is not our current one and is not using this procedure. A letter was mailed to members in July 1973, again bringing this to their attention and also providing information on revisions in the surcharge program previously approved by our Committee.

(3) Members of the Committee, Society officers and staff attended a meeting, arranged for by the broker, with officers and employees of our current insurance carrier and the attorneys involved in defense of professional liability suits against Society members.

The program included a resumé of nationwide developments in malpractice and a review of our insurance company's attitude as regards this form of insurance. A substantial portion of the program involved a review of current legal conditions and trends taking place in New Jersey.

The Committee also took the following action relative to the providing of insurance:

(1) *Acupuncture*—this procedure is considered by the State Board of Medical Examiners to be the practice of medicine and only to be performed by a properly licensed physician. It was agreed that our program would offer professional liability insurance to all members practicing acupuncture; that acupuncture would be placed in class five; and that the Joseph A. Britton Agency would furnish each physician with the proper consent form to be used for all procedures.

(2) *Paramedics* (Physicians' Assistants)—the Committee recommended that coverage be declined inasmuch as paramedics are not licensed and not recognized by the State Board of Medical Examiners.

(3) *Health Maintenance Organizations*—The Committee recommended that all eligible participants must be members of The Medical Society of New Jersey in order for liability insurance coverage to be made available to the organization by our broker.

A resolution for *mediation,* to be submitted to the 1974 convention, was also referred to the Committee for evaluation. This approach is currently used in one judicial branch in New York City. There are indications that mediation, as currently invoked, does not lead to a reduction in the number of active suits *via* voluntary dismissal or withdrawal. It appears the primary way claims are disposed of is by settlement. Mediation also superimposes another level of pre-trial conferences which is already required in New Jersey.

Considering these factors, the Committee does not recommend this approach.

The Committee also evaluated a proposal for a *self-insured retention plan.* This plan involves substantial assessment against each member for creation of a fund to pay claims and suits within certain limits, with reinsurance purchased over this basic coverage. This proposal was not approved in that it appeared certain administrative functions plus unknown long term costs involving substantial risks could develop for the Society and also, that it did not offer the security of our current program.

New developments continue in the professional liability insurance field. The New York Medical Society has been advised that its present carrier no longer wishes to continue the program despite the reported willingness to accept a 50 percent rate increase. It is "rumored" that a 300 percent increase may be in order to support future losses.

In New Jersey, a number of physicians acknowledged that they will have to pay indemnity on claims and suits made against them because they were insured with the Professional Insurance Company of New York, which is now in rehabilitation. It is highly conceivable that this company will be placed in bankruptcy shortly, at which time all costs will fall on the shoulders of these doctors. Our Committee has periodically warned against the purchase of insurance from other companies purely because of "price differential." There will always be insurance carriers who are testing the market principally on the basis of a price advantage. In a short time after their real exposures become apparent, they subsequently withdraw, materially change rates or go bankrupt, to the disadvantage of those who chose to insure with them despite such warnings. We have received requests to assist members in solving their problems arising out of insuring with these companies.

At the time of this report, there is no question there should be a moderate increase effective in 1974. The details of the increase will hopefully be known prior to the convention and a supplementary report made. An evaluation of claim statistics for losses under our program, consideration of the effects of inflation on the cost of settlements, and changes in the philosophy of the courts, and other factors, proved to the Committee that an increase is necessary.

Recommendation

That the Joseph A. Britton Agency be continued as MSNJ's Official Broker for its Professional Liability Coverage.

Approved (page Tr 142)

Statewide Blue Cross-Blue Shield Program

Since the last annual report, the Union, Hudson, and Bergen County Medical Societies have joined the Blue Cross-Blue Shield program bringing the total enrollment to 14 counties. Two additional county societies have expressed interest and one is currently polling its members. Participation by the members of the individual county societies has been excellent. More than 3,100 doctors are now participating in the plan. There has also been a 5 percent increase in the participation of the members of the original 10 counties as members who were not in the county programs have become aware of the increased benefits available under the Statewide Plan.

The program is experience-rated which means that if the claims plus reserves plus the cost of running the program are less than the total premium paid, any balance remaining is refunded to the participating doctors. The first experience period was 7-1-72 to 12-31-72 (plus claims which were incurred during that period but paid from 1-1-73 to 3-31-73). The experience was fair and a dividend of 3.68 percent of the premium they paid was returned to the participating doctors.

There was a slight increase in rates for those under 65 of 2.5 percent and a 15 percent increase for those age 65 and older. This increase was based on the close margin of the original settlement and the Blues' projections of the magnitude of cost increases of hospital and medical care. The poor claims-experience of the over-65 group also affected their rate.

Effective July 1, 1973, the program will be opened to employees of participating doctors. Each doctor has the choice of offering the coverage to his employees or not. When an employer-unit elects to join the plan, there are certain participation requirements which must be met. If an employer-unit has five or fewer full-time employees, all employees must enroll (or be covered as a dependent of someone enrolled in another Blue Cross-Blue Shield plan). For units with more than five

employees, 75 percent of the eligible employees of each unit must enroll. Again, credit is given for employees who are covered by the Blues under another plan. In addition, each employer must contribute at least the single rate for each of his employees.

Recommendation

That Donald F. Smith and Associates be continued as MSNJ's Official Broker for its Blue Cross-Blue Shield Program.

Approved (page Tr 142)
Filed (page Tr 142)

Supplemental Report

The Committee on Medical Defense and Insurance held several meetings to evaluate what changes in rates are in order for professional liability insurance.

Considering current trends and statistical data available to the insurance company, it would appear that a substantial rate increase could have been requested. However, following discussion with the company by the Society-sponsored broker, the request for increase was limited to 20 percent.

The Committee made an in-depth study of extensive statistical data and other pertinent information and agreed to recommend acceptance of the increase. It became apparent, during their studies, that certain classes of practice were contributing disproportionately to claim costs in relation to their present premiums. There is no indication that these conditions will change in the near future. As a result, the Committee recommended allocation of the increase as outlined in Column A below. This allocation is based on statistical information developed from claims previously reported under the program. Alternately, should this prove unacceptable to the New Jersey State Department of Insurance, the Committee agreed to recommend acceptance of the allocation as listed in Column B.

Class	Column A	Column B
1	15%	20%
2	—	5%
3	—	5%
4	12½%	20%
5	—	7½%
Neurosurgery	200%	100%
Orthopedics	80%	50%
6	—	—
7	—	—
0	—	—

This action was approved by the Board of Trustees on April 21, 1974. The recommended changes will also involve an increase in the charges for x-ray therapy; a separate charge for cardiac catherization; plus a minor change in increased limits tables.

In other action, the Committee accepted use of a deductible clause of $5,000 per claim for groups of 20 or more physicians. This action was also approved by the Board of Trustees on April 21, 1974.

Filed (page Tr 142)

President Boylan accepts Fellows' Pin from Immediate Past-President D'Elia

Medical Education

James A. Rogers, M.D., Chairman, Paterson

(Reference Committee "D")

The Committee on Medical Education had another very active and productive year. Since the annual meeting of May, 1973 it has succeeded in accomplishing the following:

1. It successfully demonstrated to the AMA survey team its ability to conduct surveys in the community hospitals in New Jersey in August, 1973.

2. It embarked on a program to train New Jersey physicians to survey continuing education programs in the community hospitals in the State.

3. It encouraged hospitals to seek such surveys and offered advice regarding surveys when requested.

4. It made arrangements with the AMA to jointly issue the Physician's Recognition Award (150 hours in 3 years) through the Chicago office to New Jersey physicians participating in programs accredited by MSNJ and the AMA.

5. It joined in a cooperative effort that defined the non-overlapping accreditation activities of The Medical Society of New Jersey, the Academy of Medicine, New Jersey Chapter of the Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. This agreement stipulated that the MSNJ would devote its efforts to the activities of community hospitals, the Academy to the activities of the Specialty Societies and to special educational programs in the State, the Academy of Family Physicians to all activities in its jurisdiction, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey to the programs of the College and its affiliated hospitals.

6. The goals of the understanding reached by the aforementioned groups are to effect quality and uniform standards of accreditation, to coordinate educational activities, to prevent needless duplication, and to attempt to promote a more timely and orderly rotation of subject matter.

7. In October, 1973 your Committee, in cooperation with the AMA, disseminated the pamphlet outlining the requirements for the AMA Physician's Recognition Award to all members of MSNJ. A letter by your Committee accompanied the pamphlet.

8. In April 1974, a Special Article appeared in *The Journal* of MSNJ describing in detail the categories and the requirements of the 150 hour credits over a three-year period for the Award.

9. *The Journal* of MSNJ has cooperated in listing the accredited educational activities throughout the State. It presents the events as a calendar of activities and is a central resource for such information.

The Medical Society of New Jersey has noted the increased activities of the Committee on Medical Education. It has also noted the amount of time, money, and effort required for this project and has added staff for this activity. Mrs. W. Butterfoss has been assigned full time to this project, and Mr. Martin Johnson also has this project assigned to him as one of his staff responsibilities. Your Committee gratefully acknowledges their valuable help and excellent cooperation to a difficult task.

The first hospital survey by your Committee in New Jersey was in August, 1973. At that time few physicians in the State were knowledgeable about how to conduct such surveys. But this small nucleus has steadily expanded as more and more physicians have agreed to join inspection teams. As of March, 1974, 40 hospitals have requested surveys of which almost half have been completed. More would

have been conducted if the gas shortage had not been such a problem. It is hoped that by the time this report reaches the reference committee at the annual meeting all 40 hospitals will have been surveyed.

The Committee is grateful for the voluntary effort of those who assisted in the surveys, and for the support and cooperation of the hospitals and their staff representatives. Lacking this, the progress to date could not have been achieved.

The Committee wishes to pay tribute to the late William T. Snagg, M.D., of Camden, a member of the Committee, for the tremendous amount of time and effort he spent in laying the groundwork for a statewide system of continuing medical education.

This is my last year as Chairman of this Committee. The record will show that much has been accomplished in these changing and trying times, thanks to the unselfish giving of time and effort by all members of the Committee. Furthermore, many more who were not on the Committee rendered valuable assistance, advice, and service. Without such cooperation, this progress could not have been accomplished.

Acknowledgement is due to the Academy of Medicine, the Academy of Family Physicians, the New Jersey Association of the Directors of Medical Education, and to the College of Medicine and Dentistry of New Jersey.

The quality of the continuing medical education programs in this State must remain high through systematic surveillance and accessible expertise. We can, and must encourage our colleagues to demonstrate the effectiveness of a self-initiated, voluntarily-implemented system.

The chairman takes this opportunity to express his gratitude and thanks to the members of the Committee, to the consultants, to the many volunteers, and especially to the staff of MSNJ for their devoted efforts, excellent support and cooperation. I very much appreciated the confidence placed in me and the opportunity to serve.

Filed (page Tr 144)

Medical Student Loan Fund

William Greifinger, M.D., Chairman, Essex

(Reference Committee "B")

In its seventeen years of operation the Medical Student Loan Fund has granted loans totaling $360,144.35 including $444.35 as insurance payments, bringing the net loans granted to $359,700.

To date the Fund has issued 318 loans to 198 New Jersey medical students. One hundred and seven loans have been repaid in full. Thirty borrowers are presently making quarterly repayments on an annual basis.

Requests for financial assistance by New Jersey medical students have increased from twelve in 1972-73 to thirty-three applications during the 1973-74 administrative year. It is expected that this trend will continue for some time. Out of the total of thirty-three students' requests, thirty-two were granted loans of $1,500 for a total of $48,000.

It is estimated that the Fund will have $45,000 available for loans for the 1974-75 school

year to accommodate thirty students at $1,500 each. Of this amount $16,500 is committed to eleven prior applicants, leaving $28,500 for nineteen additional student requests. Twelve applications and new inquiries received to date from qualified medical students total $18,000 giving us only $10,500 or $1,500 for seven unknown applicants at this time.

This report does not reflect all the anticipated applications from other qualified medical students and your Committee is also mindful of the ever-increasing tuition rates. However, at this time, it does not feel it can afford to increase the $1,500 yearly loan limit.

Your Committee has had continued encouraging results from its solicitation of past loan recipients now serving an internship or residency to initiate early repayment of their loans on an interest-free basis. This year three loans have been paid in full. (2 @ $1,500—1 @ $1,000). The financial activities of the Fund during the year are included in the report of the Treasurer.

Your Committee warmly commends and thanks Mr. Lambert and Mr. Squreck for their consistently efficient administrative assistance.

Present Location of Recipients of Loans

The 96 graduates are located as follows:

Interns—5 in New Jersey and 5 out-of-state	10
Residents—12 in New Jersey and 20 out-of-state	32
Armed Service—5 Army of the United States and 6 United States Navy	11
Private Practice—1 Arizona, 8 California, 2 Connecticut, 1 Florida, 1 Georgia, 2 Maryland, 1 Massachusetts, 1 Mississippi, 16 New Jersey, 1 New York, 2 Pennsylvania, 3 Texas, 2 Virginia, 1 Washington, D.C., 1 Wisconsin	43
Students presently in medical school—19 seniors and 11 juniors	30
Current student loans outstanding	126
Medical students paid in full (107 loans)	72
Total New Jersey medical students (as listed earlier)	198

Contributions

The Committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of contributors since the last report follows:

General Fund

The Medical Society of New Jersey, Board of Trustees; MSNJ's Woman's Auxiliary Executive Board; County Medical Societies: Burlington, Cape May, and Middlesex. County Woman's Auxiliaries: Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic, Sussex, Union, and Warren. American Association of Medical Assistants, Mrs. Louis Abbamonte,

Dr. and Mrs. Samuel T. Bernson, Dr. and Mrs. Nicholas A. Bertha, Dr. and Mrs. Alexander Bertland, Dr. and Mrs. James Brennan, Mr. and Mrs. F. J. Burke, Chevron Oil Company, Mrs. Judith De Franceaux, Dr. and Mrs. Sol S. Ellenson, Mr. and Mrs. Stanley Evanowski, Father and Son Post #435, The Fellowettes, Mildred Fiorito, Dr. and Mrs. Philip Fiscella, Mr. and Mrs. Harold Freeman, Mr. and Mrs. Andrew Gandek, Mr. and Mrs. B. Stanley Gandek, Mrs. Charles Gandek, Dr. and Mrs. Douglas Hammett, Mr. and Mrs. Thomas Hanson, Mr. and Mrs. Jack Hicks, Mr. and Mrs. Peter Hlinka, Dr. and Mrs. W. Robert Jacobs, Joseph R. Jehl, M.D., Mr. and Mrs. Orlo A. Keene, Dr. and Mrs. John F. Kustrup, The Reverend and Mrs. James Martin, Mrs. Marcella A. Mulligan, N.J. Turnpike Authority, Toll Supervisors Association, Mr. and Mrs. Robert E. Pardun, Jr., Dr. and Mrs. Paul H. Pettit, Mr. and Mrs. John Poliero, Mr. and Mrs. J. M. Ruggieri, Dr. and Mrs. John Scillieri, Dr. and Mrs. Edward Sherwood, Dr. and Mrs. Wayne Stewart, Dr. and Mrs. Stanton H. Sykes, Mrs. Leslie R. Taber, Mrs. Lucius Tarchiani, Margaret B. Thompson, Trinity Methodist Choir, Highland Park, N.J., Mr. and Mrs. Thomas J. Walsh, Mrs. E. Lloyd Watkins, Mrs. Ralph Wayman, Mrs. Irving Weiss, Ethel B. Williams, Mrs. Robert Zullo.

In Memory Of

Mr. Joseph Berg, Ivy Brooks, Carolyn Bumgardner, Mrs. Ralph K. Bush, Mrs. M. Yale Byer, Herman Cohen, M.D., Anita Crocco, Daisy D. Cutshall, Henry A. Davidson, M.D., Ida Di Lorenzo, John P. Dirr, M.D., Arthur E. Ely, Fred Frei, Arthur H. Gager, Robert S. Gamon, Jr., M.D., Charles Gandek, M.D., Mrs. Patrick D. Gerard, Floyd D. Gindhart, M.D., James Reginald Harman, M.D., Ralph K. Hollinshed, M.D., Albert E. Kay, M.D., Henry Kiechlin, Rose Krasner, Joseph M. Kuder, M.D., Frank Kudlack, Mrs. Anthony Lettiere, Jack Levin, M.D., Milton L. Lieberman, M.D., Elias E. Long, M.D., Elik Mahadeen, Archie Marcus, Josephine and Vincent Melillo, Father of Edward Merrey, Mr. Joseph Miller, Sidney L. Neiderhoffer, M.D., Mrs. Francis O'Brien, Anthony Riggio, Donald J. Rosato, M.D., Harold Rubin, M.D., Mrs. Anna Rose Russo, George F. Shugert, M.D., Joseph T. Smith, Dr. and Mrs. Timothy H. Spillane, Mother of Ciro S. Tarta, M.D., Mother of Mr. John Tarta, Charles K. Thurston, Father of I. B. Werner, D.D.S., Mother of I. B. Werner, D.D.S.

In Honor Of

Mrs. Louis Abbamonte, Albert Barker Kump Memorial, Dr. and Mrs. Sol S. Ellenson's Granddaughters, Mrs. Charles Gandek, "Susie" Kempler, MSNJ's Woman's Auxiliary Executive Board, Mr. Richard I. Nevin, Past Presidents Passaic County Woman's Auxiliary, Dorothy Scillieri's Presidency of Auxiliary.

Recommendations

(a) That the House of Delegates concur in the recommendation of the Finance and Budget Committee—approving a budget appropriation of six thousand dollars in lieu of a special per capita assessment for 1974-75 in support of the Medical Student Loan Fund.

Approved (page Tr 141)

(b) That the MSNJ membership be urged to continue their active support by sending contributions to the Fund.

Approved (page Tr 141)

(c) That the Woman's Auxiliary to The Medical Society of New Jersey be requested to make the Fund one of its chief projects for next year.

Approved (page Tr 141)
Filed (page Tr 141)

County of Residence	*Medical School*	*Students*	*1957-73*	*Loans Granted 4/1/73-6/1/73*	*6/1/73-3/31/74*
Atlantic	Hahnemann	3	$ 3,000		
	N.J. Medical	1	1,000		
	Pittsburgh	1	2,000		
	Temple	1	1,000		
	Tufts	1	4,000		
Bergen	Boston	1	1,000		
	Creighton	1	1,000		
	Hahnemann	3	5,000		
	Jefferson	2	4,500		
	N.J. Medical	9	14,000		
	N.Y. Medical	2	2,500		
	Rutgers	1			$ 1,500
	St. Louis	2	3,000		
	Stritch	1	3,000		
	Tufts	1			1,500
Burlington	Duke	1	4,000		
	Hahnemann	1	1,000		
	Jefferson	3	9,500		
	Med. Coll. of Pa.	1			1,500
Camden	Hahnemann	4	6,500		
	Jefferson	3	5,000		
	Michigan	1	2,000		
	N.J. Medical	2	2,700		
	Temple	5	7,500		
Cumberland	Jefferson	1	2,000		
Essex	Albany	1	4,000		
	Bern	1	2,000		
	Duke	1	2,000		
	Georgetown	2	1,000	$1,500	
	Hahnemann	3	8,000		
	Howard	1	300		
	Jefferson	1	3,000		
	N.J. Medical	20	30,900	3,000	7,500
	N.Y. Medical	2	2,000		
	Stanford	1	3,000		
	St. Louis	1	500		
	Temple	1	1,000		
Gloucester	Hahnemann	1	1,000		
	Temple	1	2,000		
	Virginia U.	1	1,000		
Hudson	Boston	1	1,500		1,500
	Georgetown	1	1,000		
	George Washington	1	3,000		
	Hahnemann	1	1,500		

County of Residence	Medical School	Students	1957-73	Loans Granted 4/1/73-6/1/73	6/1/73-3/31/74
Hudson	Harvard	1	1,000		
	Howard	1	400		
	N.J. Medical	22	28,650		4,500
	N.Y. Medical	1	1,000		
	Pittsburgh	1	3,000		
	St. Louis	1	2,000		
Hunterdon	Rutgers	1			1,500
Mercer	Georgetown	2			3,000
	Hahnemann	2	3,000		
	Howard	1	1,000		
	Johns Hopkins	1	1,000		
	Louisville U.	1	4,500		
	Meharry	1	250		
	Mississippi	1	3,000		
	N.J. Medical	5	9,500		
	N.Y. Medical	1	1,500		
	Univ. of Pennsylvania	1	1,000		
	St. Louis	1	700		
Middlesex	Georgetown	1	1,500		
	Hahnemann	1	4,000		
	Stritch	1			1,500
	Rutgers	1		1,500	1,500
	N.J. Medical	1		1,500	
	N.Y. Medical	1			1,500
	Wisconsin	1	1,500		
Monmouth	Columbia	1	2,000		
	Duke	1	3,000		
	Einstein	1			1,500
	Georgetown	1	1,000		
	Jefferson	2	6,000		
	Marquette	2	3,500		
	Med. Coll. of Pa.	1	1,500		
	N.J. Medical	3	10,000		
	N.Y. Medical	1	4,000		
	Stritch	1	4,500		
	Temple	1	2,000		
	Up-State N.Y.	1	1,000		
Morris	Dartmouth	1	1,000		
	Duke	1	1,000		
	N.J. Medical	3	3,000		3,000
	Stritch	1	1,500		
Ocean	Med. Coll. of Pa.	1	1,500		1,500
	Rutgers	1			1,500
Passaic	Jefferson	1	3,000		
	N.Y. Medical	1	1,000		
	Wisconsin	2	3,000		
Salem	Duke	1	1,500		
	Jefferson	1	3,000		
Somerset	Georgetown	1	1,000		
	N.Y. Medical	1	2,000		
	Temple	1	3,000		
	Western Reserve	1	1,000		
Union	Florida	1	1,000		
	Hahnemann	1	1,000		
	Jefferson	1	1,500		
	N.J. Medical	12	19,300		1,500
	N.Y. University	2	1,500		3,000
	Wisconsin	1			1,500
18 Counties	37 Medical Schools	198	$311,700	$7,500	$40,500
	Total loans granted 3/31/74				$359,700

Publication

Daniel B. Roth, M.D., Chairman, Teaneck

(Reference Committee "B")

In the year of 1973, the Society sustained a grievous loss, in the death of Dr. Henry A. Davidson, our long-time Editor. Your Committee functioned as an interim board from Dr. Davidson's death at the end of August until the beginning of October when the Board of Trustees appointed Dr. Arthur Krosnick as the new Editor. It is a choice in which your Committee heartily concurred. Under Dr. Krosnick's leadership *The Journal* will continue the fine work done by Dr. Davidson and will progress to new heights.

As part of our effort to improve *The Journal* we are seeking associate editors to assist Dr. Krosnick and also a manuscript review board. The latter will consist of physicians in various specialties who will be asked to review articles which the Editor feels are beyond his expertise. In this fashion we will achieve the maximum degree of competence in all the manuscripts we publish.

Because of the economic situation and uncontrolled inflation there continues to be a wide gap between the cost of publication and our advertising revenue. This gap has to be accommodated from dues money. Additionally, the Federal Government requires that dues' allocation must be made in order to preserve tax-exempt status. Your Committee and the Editor are making every effort to run the publication in the most economical manner possible.

Filed (page Tr 141)

Speakers' Table—Dinner-Dance Honoring President and Mrs. Boylan—Dr. John J. McGuire, Toastmaster

Revision of Constitution and Bylaws

Hillel M. Ben-Asher, M.D., Chairman, Morristown

(Reference Committee on Constitution and Bylaws)

This year the Committee had only one proposal before it which was processed according to the requirements of the Society Bylaws.

Proposed Amendment to the Bylaws
Qualifications of Members

In a recent United States Supreme Court decision, state statutes requiring United States citizenship or declaration of intent prior to licensure as a professional practitioner have been declared unconstitutional. Voluntary associations such as The Medical Society of New Jersey may, however, continue such a requirement prior to granting membership. The Board of Trustees believed that MSNJ should continue to carry such a condition of mem-

bership and requested preparation of an appropriate amendment to the Bylaws by deletion of the phrase under Chapter XI, Section 2, Subsection (b) (1) of the words "with the State Board of Medical Examiners."

Your Committee unanimously concurs with the decision of the Board of Trustees.

Recommendation

That the following amendment to the Bylaws be adopted.

Approved (page Tr 137)

Chapter XI—Component Societies
Section 2—Qualifications of Members

Current	*Proposed*
(a) Component Societies shall have the responsibility to judge the qualifications of an applicant for any type of membership and alone shall have the power to elect him, but election thereto shall be contingent upon clearance of each eligible applicant's formal credentials as satisfactory by the Committee on Credentials of this Society.	(a) Same
(b) To be eligible for membership, the applicant must	(b) Same
(1) be a citizen of the United States or have filed with the State Board of Medical Examiners a formal declaration of intent to become a citizen;	(1) *be a citizen of the United States or have filed a formal declaration of intent to become a citizen;*
(2) hold a degree in medicine acceptable to this Society obtained from a medical school approved by this Society at the time of his graduation;	(2) Same
(3) be fully licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners;	(3) Same
(4) be legally registered under that license in a county of New Jersey;	(4) Same
(5) be of good moral and ethical standing; and	(5) Same
(6) not support, or practice or claim to practice any exclusive system of medicine.	(6) Same
(c) When a physician applies to a component society for membership in any category, or for membership by transfer from another state, the secretary of the component society shall forward the name and address of the applicant to the biographic department of the American Medical Association for such information as may be on file relative to the applicant's record.	(c) Same
(d) All records of formal actions concerning new and transfer members shall be compiled on forms to be supplied by the Committee on Credentials.	(d) Same
(e) In order to retain active membership in this Society the member must hold a current Certificate in Continuing Medical Education from MSNJ's Committee on Medical Education. This Certificate will be bestowed upon members who complete acceptable programs of continuing education for a total of 150 hours in a given three-year period. This program is to be administered by the Committee on Medical Education in accordance with policy approved by the Board of Trustees and affirmed by the House of Delegates. The Committee on Medical Education may, with the approval of the Board of Trustees, and for good cause, shown, grant specific exemptions to this subsection.	(e) Same

Adopted (page Tr 137)

Filed (page Tr 137)

"Hawaiian" Night

Woman's Auxiliary Advisory

William J. Roe, M.D., Chairman, Englewood

(Reference Committee "H")

After attending the Quality of Life Congresses in Chicago, health education has taken on greater importance in the auxiliary activities. Auxiliary members have become acutely aware of the need of health education in all phases of human life. Also, there is a greater interest in health services and family health in our own communities. As an end result, health education days have been held by many county auxiliaries; one held a seminar for seniors with over 500 senior citizens in attendance; another county held an all-day workshop in "Comprehensive Health Education in Our School System;" many top educational personnel were included in the program. This spring another county auxiliary will present a prominent physician whose interest lies with the "Battered Child." Many more such programs have been given and with follow-up action. It is as true today, as when it was first said, "Never underestimate the power of women."

The Woman's Auxiliary health career program has seen a resurgence of action under the new name of health manpower. The Auxiliary has taken over the New Jersey Health Careers Service program and presently is working in the school systems with film strips, tapes or records, and information on more than 200 health careers available to students.

AMA-ERF—Members of the Auxiliary have been invited by the President of the College of Medicine and Dentistry of New Jersey to attend the first public relations day. The highlight of the day will be the presentation of the monies raised by the Auxiliary for the medical schools of New Jersey through AMA-ERF. It is hoped that the move will bring closer communication between the Auxiliary, the Medical Society, and the medical schools in New Jersey.

While the Women's Auxiliary is very proud of the above programs, many other women have served on other exciting committees—legislation for one. A few members have run for political offices. Still, other members give of their time and talents in local organizations.

Doctors' wives are busy wives.

Filed (page Tr 151)

Woman's Auxiliary President, Mrs. John Abbamonte, accepts Fellowettes' Pin from President Boylan

Administrative Council

Legislation

Henry J. Mineur, M.D., Chairman, Cranford

(Reference Committee "E")

This report presents a summary of the ultimate status of legislative measures of primary concern to the Society in the 1974-75 Legislature.

The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in official bulletins dispatched to State Legislative Keymen and to component societies, and in items published in the *Membership Newsletter* and *The Journal*. The minutes of the meetings of the Board of Trustees include full reports of the Council's actions taken in regular meetings.

The Council on Legislation continues its established policy of inviting an official representative from each specialty society to all Council meetings. Although a notice announcing the date of each of the Council's meetings is sent to all MSNJ's Official Intermediaries with New Jersey Specialty Societies, the attendance of those representatives at the Council meetings remains small. The Council urges that more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields.

This year the Council on Legislation agreed that in order to fortify our stand on legislative bills and make our position known throughout the Society that it be a standing policy to invite the chairman of each Council and standing committee to attend the legislative meetings and to give them the right, if they cannot attend, to select a representative.

We have also taken steps to register Mr. Johnson of The Medical Society of New Jersey staff as a lobbyist and coordinated his activities with those of Mr. Meara to provide improved input in the Legislature.

The Keyman system is being revamped and will, hopefully, become a more effective mechanism. We expect to complete this phase of the operation in July.

Further, at our request, the Board of Trustees has appointed an Ad Hoc Committee to Study and Redefine the Role and Function of the Council on Legislation.

Of the bills reported to the House in 1973, the following were signed into law:

APPROVED: S-180, S-830, S-1000, S-1062, S-1264, S-2135 A-329, A-944, A-1204, A-2317, and A-2440

DISAPPROVED: A-1474—To provide that no dog licenses shall be issued unless the owner provides evidence that the dog has been innoculated with antirabies vaccine.

ACTIVE OPPOSITION: A-819—To provide that the Board of Medical Examiners shall charge fees for licenses to practice medicine and surgery as provided for in the statutes and where not so designated such fees shall be prescribed by rule or regulation.

The following list of bills were referred back to the Council on Legislation by the House for reconsideration:

S-852 —To require every school bus transporting children to and from school shall be staffed with a monitor at least 16 years of age. *DISAPPROVED,* because the effect of the bill is already covered in the voluntary administration of school policies.

S-1041 —To regulate the practice of ophthalmic dispensing. *DISAPPROVED,* because this bill places unwarranted restrictions upon the practice of ophthalmology and medicine and would expand the practice of ophthalmic dispensers and ophthalmic technicians without providing circumstantial safeguards for the public good.

S-1054 —To provide for testing of motor vehicle fuels to determine the presence of factors which may contribute to air pollution. NO ACTION.

A-836 —Requires every school bus to be staffed with a monitor at least 16 years of age in addition to the driver; effective at the commencement of the school year next succeeding enactment. *DISAPPROVED,* because the effect of the bill is already covered in the voluntary administration of school policies.

The following bills of medical interest were introduced into the Legislature in 1973, but too late to be reported to the 1973 House of Delegates:

S-2238 —To prohibit profit-making medical referral services. *APPROVED*

S-2239 —To limit circumstances under which a report of a referral for abortion services or of an inquiry or request therefor may be furnished to provide for actual and exemplary damages for willful violation. *APPROVED*

S-2256 —To provide that a notice of food establishment health deficiency shall not be posted on the premises for 10 days where the deficiency does not create an immediate health hazard. *DISAPPROVED,* because, this bill does not consider the ten-day interval in which the general public would be exposed to unsanitary conditions between detection and initiation of suspension.

S-2281 —To regulate the practice of dentistry and dental hygiene and to repeal Chapter 6 of Title 45 of the Revised Statutes. *ACTION DEFERRED,* pending further information from the New Jersey Dental Association.

S-2286 —To provide that any person, other than a person licensed to practice medicine and surgery, who performs an abortional act shall be quilty of a high misdemeanor. *APPROVED*

S-2298 —To increase license and registration fees to increase the members of the Board of Optometrists from 5 to 7 members, to provide for branch office transfer licenses, to increase penalties for violations and other amendments to the act concerning the practice of optometry. *ACTION DEFERRED,* pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

S-2315 —Designated "The Catastrophic Illness Assistance Act of 1973"; to authorize program for State assistance; appropriates $200,000. *APPROVED*

S-2317 —To provide for direct billing in certain instances for clinical laboratory services. *APPROVED*

S-2323 —To create a commission to develop a state plan for the delivery of mental health services; appropriates $25,000 therefor. *APPROVED*

S 2324 —To establish a Division of Chronic Illness Control and an Advisory Council on the Chronic Sick within the State Department of Health; to provide for state assistance to persons suffering from chronic illnesses. *APPROVED*

A-2420—To create a Mental Treatment Standards Committee to establish minimum standards of treatment for the mentally ill in state mental institutions. *ACTION DEFERRED,* pending further information from the Council on Mental Health.

A-2438—To permit equipping of school buses with seat safety belts, anchorage units, padding and other safety restraints determined necessary by local school boards. *APPROVED*

A-2440—To permit use of suitable restraining devices other than auto seat safety belts which meet standards of the Federal Department of Transportation. *APPROVED*

A-2471—To provide that no authorization for construction or operation of any solid waste disposal facility shall be given for one within a radius of 2 miles of any public or private school, hospital, nursing home, or similar institution without consent of the institution. *DISAPPROVED,* because this bill is in conflict with the expertise available in the Department of Environmental Protection and unwarrantly grants an absolute veto to certain organizations in disregard of public health.

A-2485—To prohibit employers from preventing employees who are volunteer firemen, volunteers in first aid, rescue squads or ambulance drivers from responding to alarms during hours of employment. *NO ACTION*

A-2490—To permit freeholders of a county with no hospital for care of cerebral palsy children to appropriate $100,000 for such care and in first class counties to permit appropriation of $150,000. *APPROVED*

A-2502—To require every school bus, public or private, transporting children to and from school to be equipped with electric identification and warning lamps and appropriate signs or legends. *APPROVED*

A-2503—To require all school bus drivers, public or private, to submit to a medical examination for the presence of alcohol, narcotics or habit-producing drugs.*APPROVED*

A-2509—To provide that a drug shall be deemed mislabeled if it does not contain a label with a date after which the quality of potency of the drug is not substantially equivalent to that on the date it was manufactured or produced and to permit the Department of Health to establish a list of expiration dates. *APPROVED*

A-2511—To establish a "Burn Treatment Center" in the College of Medicine and Dentistry of New Jersey. *APPROVED*

A-2519—To require the Department of Environmental Protection to adopt standards for the control of human excrement and all other hazardous and waste liquids to be enforced by local boards of health. *APPROVED*

A-2532—To require physical and mental examinations for all school crossing guards. *APPROVED*

Current State Legislation

In the afternoon of January 8, 1974, the First Annual Session (1974) of the 196th New Jersey Legislature was opened. As the Legislature presently is constituted, the Senate has a total of 40 members. The Senate is presently made

up of 10 Republicans, 29 Democrats, and 1 Independent. The Assembly has a total of 80 members of whom 14 are Republicans and official positions on all current State Legislation are regularly called to the attention of legislators as well as of component societies, cooperating agencies, county keymen, and county society secretaries and executive secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation:

*Same as bills of 1972-73

ACTIVE SUPPORT—All-out support for the measure

ACTIVE OPPOSITION—All-out opposition for the measure.

APPROVAL—Commended as satisfactory, but not actively supported.

CONDITIONAL APPROVAL—To indicate that the approval of the Society is conditional, subject to the elimination of the unsatisfactory elements of the bill that are pointed out.

DISAPPROVAL—Rejected as unsatisfactory, but not actively opposed.

NO ACTION—Considered, but not regarded as significant or relevant to the proper interest of the Society.

*S-11 —To remove exclusion of agricultural pursuits from requirements for posting State child labor abstracts; to limit farm employment of 14 and 15 year old children to periods not interfering with school and health; to prohibit farm employment of 12 and 13 year old children; to prohibit employment of minors, ages 14 and 15, near power-driven machinery and to set maximum hours of farm work for children as 8 hours. *APPROVED*

*S-108 —To correct a typographical error in P.L. 1966, Chapter 141, concerning content of alcohol in a motor vehicle violation defendant's blood. *APPROVED*

*S-110 —To authorize establishment of regional air pollution control districts by two or more municipalities. *APPROVED*

*S-117 —To require freeholders in counties with facilities for detention of children under 16 years of age to establish tutorial and mental health programs under guidelines to be established by the Commissioner of Institutions and Agencies. *APPROVED*

*S-152 —To direct the Board of Education to require immunization of all pupils against rubella as a condition for entrance to kindergarten and grades one through four. *DISAPPROVED,* because under certain circumstances immunization against rubella is contraindicated.

*S-170 —To provide that no dog brought to a pound or shelter shall be sold or otherwise be made available for experimentation. *DISAPPROVED,* because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

*S-183 —To create the New Jersey Medical Education Loan Fund in the Department of Higher Education. *APPROVED*

*S-188 —To provide that any person who knowingly possesses or sells drug paraphernalia evincing an intent to use the same for unlawfully manufacturing, packaging, or dispensing of any narcotic drug is a disorderly person. *APPROVED*

*S-197 —To provide for regulation and licensing of persons engaged in a mail order drug distribution business. *APPROVED*

*S-245 —To include under the act concerning sale or possession of hypodermic syringes, needles, or instruments the use thereof adapted for the use of controlled dangerous substances. *APPROVED*

*S-251 —To provide that no dentist shall administer a local or general anesthetic unless the State Board of Registration and Examination has certified that he has successfully passed a course in anesthesia or an examination conducted by the Board. *DISAPPROVED,* because the legislation is unnecessary inasmuch as the State Board of Dental Examiners can deal with this matter by means of regulation.

*S-256 —To provide that no person having justification over potable water shall direct mandatory fluoridation until the question has been first approved by voters in a referendum. *DISAPPROVED,* because it is a practical impossibility to achieve, by referenda, the mandatory fluoridation of the water supply of counties when many of them are serviced by a single company. For this reason The Medical Society of New Jersey, since 1971, has been on record as favoring the fluoridation of potable water supplies by means of a mandatory program under the aegis of the Department of Environmental Protection.

*S-269 —To require the State Department of Health to test all newborn infants for phenylketonuria. *DISAPPROVED,* because not all children are susceptible to the malady and also because the present testing procedure is not precise or dependable.

*S-277 —Designated "The Catastrophic Illness Assistance Act of 1973" to authorize program for State assistance; appropriates $200,000. *APPROVED*

*S-281 —To permit freeholders in counties which have no county home or hospital for the diagnosis and care of children afflicted with Cooley's anemia to appropriate not more than $5,000 each year for such care. *APPROVED*

*S-286 —To provide that any seller of age 18 and not addicted to the use of morphine, cocaine, heroin, opium or any derivative thereof shall, upon conviction, be punished by death. *NO ACTION*

*S-292 —To require adult attendants on school buses transporting handicapped children. *NO ACTION*

*S-317 —To provide for the mandatory civil commitment of drug addicts and to establish a procedure therefor. *APPROVED*

*S-337 —To remove from municipalities the authority to prosecute people for public drunkenness. *APPROVED*

*S-338 —To eliminate public drunkenness as a disorderly persons' offense. *APPROVED*

*S-347 —To provide for medical examination of school pupils who may be under the influence of drugs by either the medical inspector or any other doctor. *APPROVED*

*S-360 —To provide that no professional teaching staff member shall use any designation indicating he possesses a doctor's degree unless earned from a college whose degrees are acceptable to the State Department of Higher Education. *NO ACTION*

*S-361 —To provide for the establishment of a central registry of blood donors in the Department of Health and to appropriate $50,000. *DISAPPROVED,* because it would be a duplication of record keeping by existing blood banks in the State of New Jersey with no appreciable advantages.

*S-368—To authorize the Commissioner of Health to purchase residential and non-residential care and treatment of drug addicts and abusers in non-State facilities. *APPROVED*

*S-379 —To provide that leaves of absence shall be granted classified civil service employees for the purpose of donating blood. *DISAPPROVED,* because The Medical Society of New Jersey strongly supports the voluntary donation of blood. It holds that to grant a donor a day off with pay is to expose him to the same profit motivation that taints commercial blood giving.

*S-380 —To provide that leaves of absence shall be granted State employees for the purpose of donating blood. *DISAPPROVED,* because The Medical Society of New Jersey strongly supports the voluntary donation of blood. It holds that to grant a donor a day off with pay is to expose him to the same profit motivation that taints commercial blood giving.

*S-381 —To prohibit the sale of children's automobile seats which do not conform to the Federal Motor Vehicle Safety Standards for children's seats and harnesses and do not have affixed a date of manufacture label with instructions for proper installation. *APPROVED*

*S-382 —To provide for the licensing and regulation of day care facilities by the Department of Institutions and Agencies; to establish license fees and to establish and specify representation on New Jersey Citizens' Advisory Committee on Day Care Licensing to be composed of 20 members. *NO ACTION*

*S-386 —To provide that if the weight of alcohol in a defendant's blood is 0.07% or more, it shall be presumed that his ability to operate a motor vehicle was impaired. *DISAPPROVED,* because The Medical Society of New Jersey favors the criterion proposed in A-719 of 1972.

*S-395 —To provide for supervision of projects for prevention of blindness by the Commission for the Blind and to provide that funds shall be made available on a project basis for programs conducted by the Department of Health and organized health services groups. *APPROVED*

Upon recommendation of the Reference Committee, the position on the above bill was changed by the House from "no action" to "approved."

*S-407 —To establish a "Contracts for Health Studio Services Act" to provide for certain requirements, limitations and prohibitions concerning such contracts; to require health studios to file bonds with the Director of Consumer Affairs and to provide for recovery of damages upon, and a penalty for, violations. *NO ACTION*

*S-444 —To define child care centers to include private and public child care center, day nursery, nursery school or other establishment of similar character; to define Local Child Development Council and to provide for a Child Development Committee in the Department of Education and other amendments. *APPROVED*

*S-447 —To provide that the medical assistance program shall include the cost of drugs prescribed for persons 65 years of age and older, not otherwise eligible for assistance, who are determined by the Commissioner of Health to need such financial assistance. *APPROVED*

*S-449 —To define "qualified applicant" under the New Jersey Medical Assistance and Health Service Act to include in determinations of eligibility assistance under this program the chronic and recurring medical expenses of the family unit as a component of the standard of need. *APPROVED*

*S-499 —To provide that the act concerning the practice of medicine and surgery shall not apply to the performance of any act at the direction and supervision of licensed physician by a person working under a job description approved by the Board of Medical Examiners and possessing qualification established by the Board. *APPROVED*

*S-500 —To revise the statutory law with respect to consent by minors to performance of hospital, medical, or surgical procedures or treatment. *ACTION DEFERRED.*

*S-502 —To provide that the Department of Health shall prepare lists of family planning clinics in the State together with birth control information pamphlets for distribution by marriage licensing officers. *APPROVED*

*S-503 —To provide that no person shall be required to perform or assist in an abortion or sterilization and no hospital or other health care facility shall be required to provide such services or procedures. *APPROVED*

*S-504 —To define and include "abortion service facility" under the law concerning licensing and regulation of health care facilities. *APPROVED*

*S-505 —To prohibit profit-making medical referral services. *APPROVED*

*S-506 —To limit circumstances under which a report of a referral for abortion services or of an inquiry or request therefor may be furnished; to provide for actual and exemplary damages for willful violation. *APPROVED*

*S-508 —To provide that any person, other than a person licensed to practice medicine and surgery, who performs an abortional act shall be guilty of a high misdemeanor. *APPROVED*

*S-519 —To create a commission to develop a State plan for the delivery of mental health services; appropriates $25,000 therefor. *APPROVED*

*S-520 —To establish a Mental Care Standards Board and a Mental Patient Care and Standards Review Board. *NO ACTION*

*S-535 — To establish in the Department of Health a program for the identification, eradication and treatment of Beta Hemolytic Streptococcus infections. *APPROVED*

*S-539 —To exempt employees of a humane society from prohibition of the Controlled Dangerous Substances Act. *APPROVED*

*S-546 —To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease, or tuberculosis shall be deemed to be an occupational disease. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical investigation.

*S-569 —To provide that all insurance advertising which offers cash benefits for hospital confinement shall include a clear statement detailing the percentage of gross premium dollars which have been paid in health and accident benefits to persons insured thereunder. *APPROVED*

*S-571 —To provide that no public utility shall, during the course of any labor dispute, cancel any life insurance, hospitalization insurance, or medical insurance coverage of its employees. *APPROVED*

*S-575 —To remove from the Temporary Disability Benefits Law all limitations relating to pregnancy, miscarriage, or abortion. *NO ACTION*

*S-585 —To increase weekly maximum workmen's compensation benefits for permanent partial disabilities to 2/3 of average weekly wages of employees covered by the unemployment compensation law, to increase funeral allowances, to require free choice of physician, to establish a Workmen's Compensation Board of Appeals and other changes. *APPROVED*

*S-586 —To provide for degrees of criminal culpability for criminal possession of controlled dangerous substances. *NO ACTION*

*S-597 —To require every State agency to prepare an environmental impact statement on each project it proposes to approve or implement. *APPROVED*

*S-613 —To establish a Department of Human Services where the duties shall include development and implementation of comprehensive State plans to provide for continuity of care for all persons requesting and receiving treatment in institutions, agencies, and programs under its jurisdiction, including the fullest utilization of available community resources by purchase of care and of service contracts with private agencies and individuals, to transfer various institutions and non-institutional agencies from the Department of Institutions and Agencies and to appropriate $500,000. *APPROVED*

*S-642 —To provide that courses in public health in public schools shall include instruction in nutrition and selection and preparation of food for personal and family consumption. *APPROVED*

*S-650 —To establish weekly permanent partial disability workmen's compensation benefits as 2/3 of weekly wages received at the time of injury subject to a maximum of $60 per week, to provide for payment of $40 a week for the first 7½% of disability; to provide an additional 25% for amputations of major scheduled members; to provide for payment of previously existing cardiovascular functional disability out of a second injury fund and other amendments. *APPROVED*

*S-657 —To grant physicians and surgeons immunity from liability for services rendered at the request of police where persons are suspected of operating a motor vehicle under the influence of liquor or drugs. *APPROVED*

*S-658 —To prohibit review of a workmen's compensation award on the grounds that the disability has diminished where the injured employee has submitted to rehabilitation. *APPROVED*

S-665 —To redefine various terms with respect to the practice of nursing. *ACTION DEFERRED,* referred to Committee for Emergency Action.

*S-670 —To authorize the Commissioner of Health to contract with voluntary non-profit hospitals for early care, treatment, rehabilitation, counseling, and education of drug users and their families and to appropriate $150,000. *APPROVED*

S-681 —To provide that in family type health insurance policies, which include insurance for

newborn children, the coverage for each child shall commence with his date of birth and include, without limitation, all eligible services. *APPROVED*

S-682 —To provide that coverage under the act concerning hospital service corporations of newborn children under family contracts shall commence with the date of birth of each child and include, without limitation, all eligible services. *APPROVED*

S-683 —To provide that coverage under the act concerning medical service corporations of newborn children under family contracts shall commence with the date of birth of each child and include, without limitation, all eligible services. *APPROVED*

*S-741 —To provide that illnesses caused by hypertension, heart disease, tuberculosis, including coronary thrombosis, shall be deemed an occupational disease of fire and policemen. *DISAPPROVED,* because this bill involves diagnosis by legislation rather than by medical examination.

*S-742 —To provide under Chapter 253, P.L. 1944, that hypertension, heart disease, tuberculosis suffered by firemen and policemen shall be presumed to have been suffered in the line of duty. *DISAPPROVED,* because this bill involves diagnosis by legislation rather than by medical examination.

*S-743 —To provide under Chapter 255, P.L. 1944, that hypertension, heart disease, tuberculosis suffered by fire and policemen shall be presumed to have been suffered in the line of duty. *DISAPPROVED,* because this bill involves diagnosis by legislation rather than by medical examination.

*S-753 —To include central services facilities operated by, rather than serving, institutions within definition of "health care facility" in the Health Care Facilities Planning Act. *APPROVED*

*S-764 —To authorize the Department of Health to establish programs of rehabilitation for drug dependent persons, to provide facilities and to provide for licensing operators of such facilities. *DISAPPROVED,* because the legislation is unnecessary in view of the fact that the requested authority already inheres in the Department of Health and is being exercised through the Department's Division of Drug Control.

S-828 —To permit any first class county maintaining a maternity hospital to transfer and convey real property comprising the maternity hospital at private sale and without consideration to any municipality within the county maintaining a hospital for the sick and injured. *NO ACTION*

S-835 —To regulate the practice of acupuncture, provide standards, qualifications and certification of practitioners. *ACTION DEFERRED,* referred to Committee for Emergency Action.

S-850 —To provide additional penalty provisions under the Controlled Dangerous Substances Act with respect to Schedule I and II narcotic drugs. *NO ACTION*

S-854 —To direct the Department of Health to establish a program for the care and treatment of persons suffering from terminal illnesses and to appropriate $500,000. *APPROVED*

S-855 —To authorize the Commissioner of Health to formulate codes to restrict activities contributing to air pollution and to provide for public notice and hearings. *NO ACTION*

S-856 —To provide that the codes, rules, and regulations of the Department of Health may include requirements for industries throughout the State to install certain types of air pollution control equipment. *NO ACTION*

S-859 —To establish a Division of Consumer Health Services in the Department of Health. *NO ACTION*

S-860 —To direct the Department of Health to establish a program for the care and treatment of persons suffering from terminal illness and to appropriate $500,000. *APPROVED*

S-862 —To establish a Division of Chronic Illness Control and an Advisory Council on the Chronic Sick within the State Department of Health; to provide for State assistance to persons suffering from chronic illnesses. *APPROVED*

S-866 —To provide that no person shall store or drain or dispose of dangerous or toxic chemicals in or on the soil unless the soil is protected by a dike or shield and unless an annual permit is obtained from the Commissioner of Environmental Protection. *APPROVED*

S-885 —To provide for the establishment by the Department of Education, within the limits of available appropriations, of up to five-day school facilities for the education of children of school age who suffer from severe handicaps. *NO ACTION*

*A-14 —To require all vehicles transporting children to school to observe all traffic safety laws applicable to school buses.—*APPROVED*

*A-21 —To provide for reimbursement of licensed chiropractors for services under the act concerning medical service corporations. *ACTIVE OPPOSITION,* because the services which chiropractors are licensed to provide are not among the services covered by medical service corporations. They are not licensed or recognized as physicians or surgeons and are not qualified—or licensed—to supply medical and/or surgical services for injuries and/or disease conditions.

*A-22 —To provide for reimbursement of licensed chiropractors for services under the act concerning health insurance other than group and blanket insurance. *ACTIVE OPPOSITION,* because the services which chiropractors are licensed to provide are not among the services covered by medical service corporations. They are not licensed or recognized as physicians or surgeons and are not qualified—or licensed—to supply medical and/or surgical services for injuries and/or disease conditions.

*A-23 —To provide for reimbursement of licensed chiropractors for services under the act concerning group health insurance. *ACTIVE OPPOSITION,* because the services which chiropractors are licensed to provide are not among the services covered by medical service corporations. They are not licensed or recognized as physicians or surgeons and are not qualified—or licensed—to supply medical and/or surgical services for injuries and/or disease conditions.

*A-25 —To repeal P.L. 1971, Chapter 231, thereby restoring P.L. 1952, Chapter 230, requiring registration of narcotic addicts with the police. *NO ACTION*

*A-27 —To provide for eye examinations of every child enrolled in the kindergarten class and to permit boards of education to authorize examinations for pupils in other grade levels. *DISAPPROVED,* because the school physician already has the obligation to screen for physical defects, including impairment of vision. The additional requirement of an optometrist or a physician licensed to practice medicine in the State of New Jersey would, in consequence, be an unjustifiable and expensive redundancy.

*A-28 —To direct the Board of Education to require immunization of all pupils against rubella as a condition for entrance to kindergarten and grades one through four. *DISAPPROVED,* because under certain circumstances immunization against rubella is contraindicated.

*A-30 —To permit boards of education to provide sex education for grades 7 through 12. *DISAPPROVED,* because sex programs should not be prohibited for pupils below the 7th grade, provided the programs and teachers are carefully screened and approved and parental approval is given.

*A-46 —To require that each bio-analytical laboratory be under supervision of a person licensed to practice medicine and surgery and certified in clinical pathology or a licensed bio-analytical laboratory director. *DISAPPROVED,* because it is not in the best interest of the public. Many physicians practicing pathology are certified in anatomical pathology, but not clinical pathology although they have extensive training in that field. Many hospital laboratories are supervised by well-qualified physicians who are not certified specialists in clinical pathology. Therefore, if this bill is enacted it will create a crisis situation in many New Jersey hospitals that are providing admirable services to the community.

*A-50 —To permit applicants for examination to practice medicine and surgery to declare citizenship intent in an affidavit submitted to the Board. *APPROVED*

*A-60 —To establish a Department of Mental Health as a principal department of the State Government and to appropriate $100,000 therefor. *APPROVED*

*A-72 —To extend the statute of limitations from 2 years to 3 years from the cause of action to personal injury actions. *DISAPPROVED,* because it would unnecessarily precipitate a professional liability insurance crisis in New Jersey.

*A-77 —To provide that any child who is afflicted with the disease of sickle cell anemia shall be eligible for the care and treatment provided for crippled children. *APPROVED*

A-80 —To provide under the Uniform Anatomical Gift Act that a donor may authorize a licensed funeral director who has completed a course in eye enucleation to enucleate eyes for a gift after certification of death by a physician. *APPROVED*

A-95 —To provide that no physician shall charge a patient for completing a medical claim form in connection with a health insurance policy. *ACTION DEFERRED,* pending conference with sponsors of the bill.

*A-96 —To provide that courses in public health in public schools shall include instruction in nutrition and selection and preparation of food for personal and family consumption. *APPROVED*

*A-132 —To permit the State Department of Health and Local Boards of Health to provide at public expense for the immunization of pupils from diseases which are required to be immunized against by the State Sanitary Code. *NO ACTION*

*A-133 —To provide that it shall be an unfair trade practice for a life or health insurance company to fail to make available for issuance all the kinds of insurance stated on the insurer's certificate of incorporation pursuant to subsection (d) of R.S. 17B18-4. *NO ACTION*

*A-161 —To require physical and mental examinations for all school crossing guards. *APPROVED*

*A-168 —To require, in place of permit, employment of an optometrist as school vision examiner and a physician to be known as school hearing examiner. *APPROVED*

*A-170 —To exclude from the old age assistance law definition "lacks adequate support" all expenditures for medical services and prescription drugs for treatment of a condition of a chronic recurring nature in excess of 30% of an applicant's income and resources and shall not be included for any determination of available income. *APPROVED*

*A-171 —To provide for "occupational hearing loss" under the Workmen's Compensation Law. *APPROVED*

*A-176 —To require retired school buses presently used to transport senior citizens to recreation activities to comply with safety regulations applicable to school buses as promulgated by the Department of Education. *APPROVED*

*A-177 —To increase from 20 to 45 days the notice required for proposed administrative actions under the Administrative Procedure Act. *NO ACTION*

*A-180 —To prohibit the burning of meadows from March 16 to April 1 of each year. *NO ACTION*

*A-181 —To prohibit the taking of surf clams under 4½ inches long (episula solidissima) from any of the natural clam beds under tidal waters of the Atlantic seaboard except from December 1 to March 31 of each year and to provide for licensing. *NO ACTION*

*A-189 —To provide for the licensing of residential child care facilities. *NO ACTION*

*A-204 —To provide that any correctional institution officer who suspects any inmate of using any controlled dangerous substance the officer shall report his findings to the medical officer and the inmate shall thereupon submit to any and all valid examinations. *APPROVED*

*A-207 —To regulate the sales of medicines containing ethyl alcohol, antihistamines, destromethorphan, phenobarbital, or its salts, ephedrine or its salts or belladonna or any of its alkaloids. *APPROVED*

*A-277 —To provide that municipal, county, and regional boards of health shall provide newspapers of local and statewide circulation with the names of restaurants newly charged with health code violations and to permit use of radio and television for public announcements. *NO ACTION*

*A-237 —To provide that the act concerning licensing of physicians shall not apply to a physician or surgeon duly licensed to practice in any foreign country where requirements are not lower than in this State where such person is temporarily teaching in a medical school approved by the Board of Medical Examiners. *DISAPPROVED,* because it would circumvent the orderly and dependable procedure for licensing of physicians adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It would impose upon the State Board of Medical Examiners the almost impossible responsibility of ascertaining the standards of licensure applied in all foreign countries, and of deciding whether those standards may be accepted as equivalent to those which New Jersey imposes or to those of other states whose licenses New Jersey accepts on a basis of reciprocity.

*A-248 —To provide that any person, including a minor, believing himself a narcotic addict, may be admitted to any state or county institution having special facilities for care and treatment of drug addicts. *APPROVED*

*A-254 —To require hearing and eye examination of every motor vehicle applicant and once every six years thereafter. *APPROVED*

*A-258 —To direct the acquisition of the Margaret Hague Maternity Hospital for $1 for use of the College of Medicine and Dentistry of New Jersey. *DISAPPROVED,* because the College is primarily interested in education and should not be burdened with the administration and operation of state facilities not essential to that educational function.

*A-267 —To provide that any applicant for a medical license who in addition to supplying required proofs can show that he has been engaged in a reputable practice for 10 years shall be granted a license without further examination upon payment of a fee. *DISAPPROVED,* because it would abrogate the present discretionary powers of the Board to act on the basis of objective evidence and would impose an obligation to make subjective judgments as to what constitutes "proof," "reputable practice," and "conceded eminence and authority in his profession."

*A-268 —To provide for granting an applicant a license to practice medicine and surgery upon proving that he was examined and licensed by the appropriate body of any foreign country. *DISAPPROVED,* because it would circumvent the orderly and dependable procedure for licensing of physicians adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It would impose upon the State Board of Medical Examiners the almost impossible responsibility of ascertaining the standards of licensure applied in all foreign countries, and of deciding whether those standards may be accepted as equivalent to those which New Jersey imposes or to those of other states whose licenses New Jersey accepts on a basis of reciprocity.

*A-273 —To permit a person related to one believed to be a narcotic addict to petition the court requesting such person be admitted to a hospital for treatment of his addiction. *APPROVED*

*A-276 —Requires District and Regional Boards of Education to appoint an Advisory Commission on Narcotics. *APPROVED*

*A-278 —To authorize the Board of Medical Examiners to grant employees of a municipal hospital who hold M.D. or D.O. degrees an exemption from the licensing requirements of the act concerning licensing of physicians. *DISAPPROVED,* because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in approved training programs.

*A-281 —To provide for proration of occupational disease awards under workmen's compensation against every employer during the 5 years immediately preceding the time the employee knew, or ought to have known, the nature of his disability. *NO ACTION*

*A-290 —To require drivers of and passengers in motor vehicles equipped with seat belts to properly utilize such restraints and to permit the Director of Motor Vehicles to grant exemptions. *APPROVED*

*A-293 —To prohibit the littering of waterways and adjacent shores and beaches and to regulate marine toilets and to repeal Chapter 13, P.L. 1954, and Chapter 170, P.L. 1958. *APPROVED*

*A-314 —To provide that the Board of Public Utility Commissioners in considering new public

utility franchise applications shall consult with the Department of Environmental Protection for determination of the effect of the franchise on the environment of the area to be served. *NO ACTION*

*A-323 —To provide that no court may order the release of a person on his own recognizance if charged with the offense of treason, murder, kidnapping, manslaughter, armed robbery, rape, or sodomy of if the alleged victime is under 16 and the person is charged with offenses of carnal abuse, lewdness, impairing morals of a minor, or assault with intent to commit rape, carnal abuse, or sodomy. *NO ACTION*

*A-331 —To provide that treatment for drug abuse consented to by a minor shall be considered confidential information which need not be reported except as required by the Controlled Dangerous Substances Registry Act. *APPROVED*

*A-332 —To provide that the Commissioner of Health, with the advice of the committee, shall determine the total number of persons eligible for chronic renal disease care and treatment and shall include a sum necessary to carry out the provisions of this act in his annual budget. *APPROVED*

*A-377 —To permit persons acquitted of violations of the disorderly persons law, misdemeanor or high misdemeanor to apply for expunging the records of all evidence of the arrest. *NO ACTION*

*A-385 —To provide that contributory negligence shall not bar recovery in an action to recover damages for negligence resulting in death or injury to persons or property. *NO ACTION*

*A-389 —To provide that a person shall not be disqualified from employment by the State or any of its agencies or subdivisions solely because of a prior criminal conviction unless there is a direct relationship to the position of employment and to provide that no governmental agency may disqualify a person from engaging in any occupation, trade, vocation, profession, or business for which a license is required solely because of a prior criminal conviction but a license may be denied if the crime for which convicted relates directly thereto. *NO ACTION*

*A-417 —To provide that no licensed chiropractor, not registered to use physiotherapy modalities, shall use such modalities. *APPROVED*

*A-438 —To provide that disability or death of a policeman or fireman resulting from respiratory diseases shall be presumed to be job related. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical evaluation.

*A-450 —To provide for examination of public school pupils suspected of being under the influence of controlled dangerous substances. *APPROVED*

*A-457 —To authorize the Commissioner of Institutions and Agencies to establish a program for treatment and rehabilitation of drug addicts who are inmates of correctional institutions and to require freeholders to put such into effect in jails, workhouses, and penitentiaries of their counties. *NO ACTION*

*A-462 —To amend the law concerning operation of a motor vehicle while under the influence of narcotics to conform to the New Jersey Controlled Dangerous Substances Act. *APPROVED*

*A-464 —To provide that no person shall operate a motor vehicle on any highway of this State unless it carries for immediate use a hand-operated fire extinguisher and a portable emergency warning device. *NO ACTION*

*A-471 —To provide for degrees of criminal culpability for criminal possession of controlled dangerous substances. *NO ACTION*

*A-476 —To provide for the regulation of clinical laboratories in the New Jersey Clinical Laboratory Improvement Act. *DISAPPROVED,* because of recent amendment to the law (December 18, 1973).

*A-480 —To provide for licensing and regulating of pest control operators and to establish standards for fumigation under the New Jersey Pest Control Act. *APPROVED*

*A-489 —To require continuing education for registered optometrists in order to qualify for renewal certificates. *NO ACTION*

*A-500 —To require certain employees of pharmacists to register with the police before they have access to controlled dangerous substances. *NO ACTION*

*A-520 —To create a State Board of Acupuncture in the Division of Consumer Affairs to regulate the practice of acupuncture and the licensing thereof. *DISAPPROVED* . . . WITH ACTIVE OPPOSITION IF THE BILL MOVES, because this bill would license individuals to practice acupuncture, even though the scientific validity of acupuncture has not been satisfactorily established. Moreover, it would jeopardize the health and welfare of the public by failing to require that licensed acupuncturists meet all the qualifications imposed by the State upon individuals who practice medicine, since obviously acupuncture would fall under the definition of medical practice as set forth in R.S. 49:9-1 et seq.

*A-521 —To provide a special workmen's compensation benefit to persons totally and permanently disabled who continue to receive weekly payments beyond the period required under the Workmen's Compensation Law and to dependents of an employee killed as a result of an industrial accident and to those receiving benefits under a special fund in existence. *NO ACTION*

*A-537 —To require all motor vehicles regularly used to transport three or more children to and from school to display a sign on the rear of the vehicle stating "Caution—Vehicle Transporting Children". *DISAPPROVED,* because it is impractical of enforcement.

*A-550 —To provide that a drug shall be deemed mislabeled if it does not contain a label with a date after which the quality or potency of the drug is not substantially equivalent to that on the date it was manufactured or produced and to permit the Department of Health to establish a list of expiration dates. *APPROVED*

*A-554 —To require the Turnpike, Highway and Expressway Authorities to submit environmental impact statements to the Commissioner of Environmental Protection before undertaking major projects. *NO ACTION*

*A-566 —To give the Pesticide Control Council veto power over the promulgation, amendment, or repeal of any regulation issued by the Commissioner of Environmental Protection as provided in the Noise Control Act of 1971. *NO ACTION*

*A-584 —To require school buses transporting school children to be equipped with emergency exits including roof exits with the standards to be prescribed by regulations of the State Board of Education. *APPROVED*

*A-586 —To provide that the rules and regulations of the State Board of Education for equipment on school buses shall include a requirement that the backs of seats shall be 28 inches high and padded with energy absorbing load distribution materials and restraint systems for the drivers' and passengers' seats. *APPROVED*

*A-594 —To require labeling of frozen food that has been thawed. *APPROVED*

*A-600 —To provide that the Commissioner of Environmental Protection shall formulate rules and regulations concerning the labeling and prohibiting, conditioning, and controlling the sale of cleaning agents whose use may tend to cause adverse effects on man or the environment. *APPROVED*

*A-603 —To clarify certain sections of Noise Control Act of 1971 and eliminate veto power of the Noise Control Council. *NO ACTION*

*A-606 —To provide that a license may be suspended for any person prescribing or dispensing controlled dangerous substances in an indiscriminate manner or where the licensee reasonably knows that the substances previously prescribed or dispensed were used for illicit consumption or distribution. *APPROVED*

*A-610 —To permit the Bureau of Children's Services, any physician, any superintendent or medical supervisor of a medical facility having as one of its objects the prevention of cruelty to children to hold a child in protective custody without court order for 48 hours or until the next court session. *APPROVED*

*A-617 —To provide that no person, otherwise eligible under the Medical Assistance and Health Services Act, shall be denied eligibility for such benefits solely on the basis of the increased social security benefits effective September 1, 1972. *APPROVED*

*A-644 —To provide that firemen suffering disability or death from a respiratory disease shall be presumed to have been related to the performance of duty. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical evaluation.

*A-655 —To amend the law prohibiting use of lead paint to prohibit certain additional uses and to provide a right of action and right to damages to persons affected. *APPROVED*

*A-662 —To provide that the need for a certificate under the act providing for certification of x-ray technicians shall not apply to the technician who operates only x-ray equipment for dental radiographs and only under the direct supervision of a licensed dentist; to provide for 9 examiners, in place of 10, on the x-ray technician board. *APPROVED*

*A-663 —To provide that the presumption that a motor vehicle violation defendant was or was not under the influence of alcohol shall not arise where the alcohol content in a defendant's blood was in excess of .05% but less than 0.12%. *APPROVED*

*A-665 —To provide that when a local board of health adopts more stringent health or environmental protection ordinances or regulations than imposed by the Department of Environmental Protection it must obtain the approval of the Department. *APPROVED*

*A-668 —To provide that any person, except a licensed physician who uses hypnosis for clinical treatment to relieve a person from symptoms of illness or unwanted habits is a disorderly person. *APPROVED*

*A-686 —To provide for consent by minors to treatment for mental illness. *DISAPPROVED.* The bill, as written, is inherently unsound in that it calls for reliable judgment from an individual who by definition is incapable of rendering the same.

*A-687 —To require the certification of diagnostic information for the use of the county court at final hearings on commitment of patients in mental hospitals where continued care and treatment beyond a 20-day temporory commitment is recommended. *APPROVED*

*A-715 —To create the Genetic Disease Information and Prevention Act in supplementation of the act concerning marriage. *DISAPPROVED,* because although MSNJ approves the intent of the bill, it is presently untimely, over-simplified, and impractical of implementation because of lack of competent personnel and facilities.

*A-717 —To prohibit manufacture, sale or distribution of recycled paper, cardboard, or paper products intended for use as containers or wrappers for food products. *NO ACTION*

*A-720 —To authorize the State Board of Nursing to issue licenses for professional and practical nursing to former medical corpsmen of the United States armed forces who have successfully completed courses of instruction required to qualify for a rating of medical service technician. *APPROVED*

*A-736 —To provide that the use of terms "cut-rate", "discount", "bargain" or similar connotation in connection with prices for prescription drugs and narcotics or fees or for services relating thereto shall constitute grossly unprofessional conduct under the act concerning the professional conduct and practice of pharmacists. *NO ACTION*

*A-738 —To establish a "Contracts for Health Studio Services Act" to provide for certain requirements, limitations and prohibitions concerning such contracts; to require health studios to file bonds with the Director of Consumer Affairs and to provide for recovery of damages upon, and a penalty for, violations. *NO ACTION*

*A-741 —To provide for a medical examination of school pupils who may be under the influence of drugs by any doctor where the parents or guardian consent. *APPROVED*

*A-742 —To permit municipalities to license and regulate health studios, spas, gymnasiums and any other public facility used for instruction, training or assistance in physical culture, body-building, exercising, reducing, figure development or any other physical skill. *NO ACTION*

*A-745 —To provide for the guaranteed performance of water and sewerage systems by applicants seeking subdivision approval in which water and sewerage is to be supplied by other than a public utility. *NO ACTION*

*A 749 —To require every school bus, public or private, transporting children to and from school to be equipped with electric identification and warning lamps and appropriate signs or legends. *APPROVED*

*A-756 —To exempt certain non-prescription drugs from the sales tax. *NO ACTION*

*A-775 —To require all school bus drivers, public or private, to submit to a medical exam for the presence of alcohol, narcotics or habit-producing drugs. *APPROVED*

*A-833 —To provide for the New Jersey Occupational Safety and Health Act. *APPROVED*

*A-872 —To provide for regulation and licensing of persons engaged in a mail order drug distribution business. *APPROVED*

*A-886 —To increase weekly maximum workmen's compensation benefits for permanent partial disabilities to 2/3 of average weekly wages of employees covered by the unemployment compensation law, to increase funeral allowances, to require free choice of physicians, to establish a Workmen's Compensation Board of Appeals and other changes. *APPROVED*

*A-895 —Prohibits any impounded dog or animal to be sold for experimentation. *DISAPPROVED*, because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

A-967 —To provide that a minor, who is or professed to be addicted to a narcotic drug, and who consents to medical or surgical care, such consent shall be valid and binding as if the minor had reached his or her majority. *ACTION DEFERRED*, pending conference with sponsors of the bill.

*A-970 —To provide that no court may order the release of a person on his own recognizance if charged with the offense of treason, murder, kidnapping, manslaughter, armed robbery, rape, or sodomy or if the alleged victim is under 16 and the person is charged with offenses of carnal abuse, lewdness, impairing morals of a minor or assault with intent to commit rape, carnal abuse or sodomy. *NO ACTION*

*A-983 —To prohibit sale of baby foods containing monosodium glutamate and to provide that the rim of the cover of the container of baby food shall be completely enclosed in a metallic or plastic strip. *APPROVED*

A-1014—To repeal R.S. 45:14-16 which requires that a pharmacy prescription be strictly followed when it is being compounded, filled, dispensed or sold. *ACTION DEFERRED*, referred to Committee for Emergency Action.

*A-1037—To provide for the establishment of local and regional environmental protection agencies, define powers and procedures for their coordination with the Department of Environmental Protection and to appropriate $50,000. *NO ACTION*

*A-1049—To provide that it shall be the duty of the board of education to provide suitable educational facilities for any pupil suspended or expelled from a public school for more than 7 days and that such pupil shall be examined and determined if he shall be classified as mentally retarded, communication handicapped, neurologically or perceptually impaired, emotionally disturbed, socially maladjusted, multiply handicapped or any other category of learning disability. *APPROVED*

*A-1057—To require the Department of Environmental Protection to adopt standards for the control of human excrement and all other hazardous and waste liquids to be enforced by local boards of health and to appropriate $50,000. *APPROVED*

*A-1082—To provide that special need to intercept wire communications shall include a showing that the licensed physician, attorney-at-law, or practicing clergyman is personally engaging or was engaged over a period of time as part of a continuing criminal activity. *NO ACTION*

*A-1097—To create a Rutgers, South Jersey Medical and Dental College Planning Council. *DISAPPROVED*, because although the Society has consistently urged and strongly supported establishment of a third medical school in southern New Jersey as soon as possible, it approved and supported the incorporation of both existing schools—at Newark and Rutgers—under the title of "The College of Medicine and Dentistry of New Jersey" and under the control of one Board of Trustees. We hold that a third school

should be under the same corporate title and the same Board's control.

*A-1127—To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease or tuberculosis shall be deemed to be an occupational disease. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical investigation.

A-1134—To provide that non-compliance with motor vehicle standards set out in R.S. 7:27-15.4 re pollution standards by August 1, 1974, shall not be cause for rejection of motor vehicles upon inspection. *NO ACTION*

*A-1145—Prohibits the application of pesticides when there are persons in or near the area to be sprayed or dusted. *DISAPPROVED,* because it would impose extreme restrictions, which for all practical purposes would make the spraying of pesticides impossible with consequent disadvantage to the public welfare.

*A-1146—To permit qualified technical aides to perform limited medical procedures ordered by a responsible licensed physician. *APPROVED*

A-1178—To provide that the head or Chief Administrative Officer of the Department of Health shall be qualified by training and experience to perform the duties of his office; to delete the requirement that he be a licensed physician. *ACTIVE OPPOSITION,* because the obligations of the Commissioner of Health demand that he be a licensed physician experienced in public health, disease patterns, and epidemiology. There are qualified applicants available both within the State of New Jersey and across the country. Therefore, there is no valid reason to downgrade the office.

A-1227—To remove the requirement that a person must be a citizen of the United States to receive a license to practice medicine or surgery in this State. *NO ACTION*

A-1239—To permit any first class county maintaining a maternity hospital to transfer and convey real property comprising the maternity hospital at a private sale and without consideration to any municipality within the county maintaining a hospital for the sick and injured. *NO ACTION* LAW c. 8 (1974)

Federal Legislation

National Health Insurance

At this writing there are at least 15 bills relating to National Health Insurance before the United States Congress. Of all the proposals the most significant is the *Comprehensive National Health Insurance Act of 1974.* This measure is jointly sponsored by Congressman Wilbur D. Mills (D—Arkansas) and Senator Edward M. Kennedy (D—Massachusetts). The bill is so newly introduced it does not yet have an assigned number. It is the most sweeping and far-reaching of all the plans being considered. Some of the salient features of interest to physicians are provided below. Please bear in mind that the verbiage being quoted is that of the sponsors and not your Council on Legislation:

1. The Federal Government must not remove the freedom of every physician and every patient to choose where and how they will give or receive health care.

The Federal Government must not take over ownership of the various elements of the health care system.

Neither the Federal Government, nor any of its agents, should make any medical judgments in a patient's care; this function is reserved solely to the responsible physician and his peers.

The Federal Government should not make community policy, but should offer financial and technical support, and information and guidelines based on national planning to support local policy formulation.

2. *One System for All Americans*—Our bill follows the essential principle of one level of health care for all Americans. Every American regardless of the source of his income would be protected by the contributory health insurance system from the day he is born through old age. Medicaid is repealed and social security and welfare recipients are included in the program on a contributory basis. Each person will be protected under the National Health Insurance Program until he is eligible for Medicare.

Benefits—Our bill would provide benefits similar to those proposed by the Administration—that is, inpatient hospital services with no day or dollar limitation; physicians' services in home, office, or elsewhere with no dollar limitation; and a variety of other medical services which in general would be subject to an annual deductible of $150 and 25 percent coin-

surance. However, we would not apply deductibles to preventive services of particular importance in promoting the health of the next generation—prenatal care, well-child care, dental care for children and so on. We believe it is of great importance to remove any possible barrier to the receipt of such care for children and to put a major emphasis in any national health insurance plan on protecting the health of children.

Continuous Coverage—While our proposed benefits are similar to those in the Administration's recent proposal, we have adopted a coverage approach that covers the worker from job to job as in social security and does not tie coverage to work with a particular employer. In this way, we avoid the gaps in protection and the complications inherent in any approach which rests on the concept of requiring each employer to pay protection for his own work force.

We propose to finance our contributory plan by having every employer pay the same percentage of payroll and every employee pay the same percentage of his earnings, as is the case in social security rather than, as in the Administration's plan, compelling employers and employees to pay the experience-rated costs of health care for the labor force of the particular employer. We are greatly concerned that experience-rated premiums, employer by employer, as in the Administration's plan, rewards the employer who refuses to hire older workers, handicapped workers, and all those who are most likely to have higher health costs.

The community-rated premium determined nationally in our plan calls for a contribution from employers of 3 percent of payroll up to an earnings level of $20,000 and a contribution from the employee of one percent of earnings up to $20,000. Those with unearned income but without earnings from work would also contribute under the program on the basis of contributions on their unearned income.

Although benefit costs are approximately the same as the Administration's plan, our approach saves over 5 percent of total benefit costs—which we have used for improved benefits—by relying on a social security collection approach and thus avoiding certain private insurance costs such as marketing.

Significant Role of Private Insurance Carrier—Under our proposal, private insurance and Blue Cross-Blue Shield plans would have a significant role in the administration of the program—as far as physician and other non-institutional services are concerned, their selection and role would differ from that now in use in the Medicare program. In addition, our bill would encourage private insurance to combine the basic government program with supplementary health benefits and other group insurance benefits in a variety of ways. For example, our bill would leave about one-half of a median-income family's health costs available for private insurance supplementation. But we see no purpose to be served and much difficulty and expense in the notion of running an essentially compulsory, government-required system through the existing marketing mechanism of private insurance.

National Health Insurance Trust Fund—We propose that the contributions of employers and employees established on an average or national community-rated basis, be set aside in a special National Health Insurance Trust Fund. The transactions of this trust fund and the transactions of all the trust funds of our comprehensive social security system would be separated from the general budget just as they were prior to the fiscal year 1969 budget. In the case of this proposed National Health Insurance Plan and in all our social security programs, we are dealing with what is essentially a group insurance and retirement system operated by the government in trust for those covered by the program. These funds are not and should not be available for any other purpose and they do not belong in the general budget.

3. *Separate Social Security Agency*—Our bill sets up a new agency of government reporting directly to the President and headed by a bipartisan board. This new Social Security

Board would be made up of the present Social Security Administration and in addition, would have responsibility for administering the new National Health Insurance Program. The Social Security Administration today, with its 70,000 employees and some 1,300 offices across the country and with responsibility for the social security cash benefit program, medicare and supplemental security income, is already one of the largest agencies of government and in any event, should not be a subordinate part of some other agency. Even more importantly, however, the concept of social security as a group insurance-retirement system calls for a separate board administration and an independence from politics.

4. *Health Development Resources Board*—We have been very mindful of the need for coordination between the administration of the new National Health Insurance system and the responsibility of planning for the development of health services and facilities. Thus, our bill would create a National Health Development Resources Board within the Department of Health, Education, and Welfare and assigns to it the continuing responsibility for the development and the effective availability of covered services throughout the Nation. The National Health Insurance Trust Fund would make a regular and substantial contribution to the work of this resources board and both the Chairman of the new Social Security Board and the Chairman of the National Health Development Resources Board would be members of a National Health Insurance Resources Advisory Council.

5. *Incentives for Efficiency and Quality*—Rather than simply passing dollars out to providers, the health insurance mechanism must be used as a means of increasing efficiency and improvements in the health care system. Our bill contains several provisions designed to carry out this objective. The proposal would require that Professional Standards Review Organizations review all services reimbursed by the program within two years of the effective date for the payment of benefits.

Institutional providers would be paid on a prospective budget basis incorporating incentives for efficiency, and would only be reimbursed for types and volumes of services certified by State and local health planning agencies.

Professional providers would be reimbursed on the basis of fee schedules set by the professional community itself but restrained in overall cost by a total base year expenditure level. Overall expenditures would be allowed to rise in accord with a wage and price index similar to the present medicare arrangement, but the fee schedule itself could be changed at the initiative of the profession.

Physicians choosing to participate in the program would be paid the standard fee (including deductibles and coinsurance for which the patient would be billed later by the plan) for all procedures for all patients and, in return, would agree not to charge the patient any additional amounts. Non-participating physicians would bill their patients as they wished and collect their own bills with the plan paying their patients the standard fee minus deductibles and coinsurance.

Institutional providers of care would be required to meet conditions of participation.

In addition, the program would encourage the start-up of forms of health care organizations, such as HMO's, that offer greater efficiency.

6. *Health Credit Card*—Our proposal incorporates the Administration's plan for a health credit card. Thus, the patient would not need to pay deductibles and coinsurance at the time services were rendered but would be billed later by the plan.

7. *General Revenue Program for Low-Income Americans*—There is a separate program for low-income Americans paid for from general revenues which on an income-tested basis assists such families in meeting the costs of deductibles and coinsurance.

8. *Medicare Improvements*—The medicare program for people 65 and over and those totally disabled social security beneficiaries who have received cash benefits for at least two years is retained as a separate program, but wherever the provisions of the new National Health Insurance system are more generous—as for example in removing all limitations on the number of days paid for in a hospital—the more generous provisions have been added to the Medicare program.

9. *Long-Term Care*—The benefits in the bill that we have described so far are quite similar to those in the Administration's bill and as indicated, have approximately the same costs. In one major respect, however, the bill we are introducing will add a totally new program as a separate part of medicare over and above anything in the Administration's proposal. Just as our bill recognizes the special needs among the young for preventive services to give them a start toward a healthy life, so does it recognize the special needs of those in old age. The bill, therefore, establishes a new program under Medicare to meet the long-term care needs of the elderly and the severely disabled. We believe that the addition of this new program will complete the goal we have of assuring a comprehensive approach to the health needs of all Americans.

We maintain a high degree of financial participation in the program by the States and require a monthly premium of those who voluntarily enroll under it similar to that paid for medical services under Medicare.

This additional program will have some additional cost associated with it, primarily in later years when the program would become fully effective. However, preparing estimates of the cost of the long-term care provisions is extremely difficult since there are few insurance precedents, and they have not yet been completed.

The addition of these provisions in the bill means that we are able to repeal the medicaid program with all of its complexities and inequities.

Conclusion—We have sought to incorporate and reconcile the many insights and virtues included in the growing body of legislative proposals submitted to the Congress so as to develop a program that would achieve the various agreed-upon objectives—support continuing improvement in the quality and accessibility of care, cover all appropriate health care needs without creating incentives for using one service when another one would do as well, safeguard the expenditure of public funds by including reimbursement mechanisms designed to foster efficiency in the organization, management, and delivery of services, assure effective and continuing review of services by the professional community and provide for the creation of a responsible partnership between the government and the private insurance community in the ongoing administration of the program.

We have welcomed the contributions of a large number of Senators and Congressmen to the provisions of the bill and, particularly on the benefit package, we have relied extensively on the proposal of the Administration.

We now call on all Senators and Congressmen and on the Administration to join us in a constructive effort to build the consensus needed to enact the National Health Insurance Program so desperately needed by the American people.

We call on health care providers and patients, representatives of all organizations with a special interest in the provision of proper health care and on experts on our health care system in this effort to build a consensus for a comprehensive, universal national health insurance system.

Your Council is holding this bill under consideration pending report analysis and comment from the AMA Legislative Department.

Comprehensive Planning

S. 2994, the National Health Planning and Development Act of 1974 would repeal the Comprehensive Health Planning Act and the

Regional Medical Program legislation and establish a nationwide system of planning and development of health services—through Health Planning Agencies—as well as specific government regulation including rate-setting authority over health services (through State Health Commissions). This measure declares health care services a public utility and imposes the Secretary of HEW as the reigning czar. State Health Commissioners would be under the direct control of the Secretary of HEW.

The AMA has registered strong opposition to the entire bill. The AHA supports major elements within the pending measure but feels it would be unsound to mix planning and regulatory functions in the same agency because inevitably the regulatory activities dominate the planning activities.

Your Council will be considering S. 2994 at its April 18, 1974 meeting and will submit a recommended position to the House in its Supplemental Report.

Filed as amended (page Tr 145)

Supplemental Report

At its meeting on April 21, the Board of Trustees considered and acted upon recommendations from the Council's meeting of April 18. The Council therefore offers this Supplemental Report covering items dealt with since the compilation of its annual report.

Federal Legislation

S.2994—the National Health Planning and Development Act of 1974 would repeal the Comprehensive Health Planning Act and the Regional Medical Program legislation and establish a nationwide system of planning and development of health services—through Health Planning Agencies—as well as specific government regulation including rate setting authority over health services (through State Health Commissions). This measure declares health care services a public utility and imposes the Secretary of HEW as the reigning Czar. State Health Commissions would be under the direct control of the Secretary of HEW. *ACTIVE OPPOSITION*, in coordination with the position taken by the American Medical Association.

Current State Legislation

The following list presents the official position of The Medical Society of New Jersey regarding additional bills currently in the Legislature.

S-269 —To require the State Department of Health to test all newborn infants for phenylketonuria. *DISAPPROVED*, because not all children are susceptible to the malady and also because the present testing procedure is not precise or dependable.

S-350 —To require psychological examinations before persons are appointed to a police department. *ACTION DEFERRED*, pending an opinion from the Council on Mental Health.

S-528 —To prohibit use of Medicaid funds for abortional services except where the mother's life must be preserved. *DISAPPROVED*, because this bill, as written, is not in conformity with MSNJ's official position on abortion and because Medicaid patients are entitled to the same quality of health care.

S-546 —To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease, or tuberculosis, shall be deemed to be an occupational disease. *ACTION DEFERRED*, pending an opinion from the Council on Medical Services.

S-658 —To prohibit review of a workmen's compensation award on the grounds that the disability has diminished where the injured employee has submitted to rehabilitation. *APPROVED*

S-665 —To redefine various terms with respect to the practice of nursing. *APPROVED*

S-835 —To regulate the practice of acupuncture, provide standards, qualifications and certification of practitioners. *APPROVED*

S-897 —To authorize the Commissioner of Health to provide for the care and treatment of drug addicts by public and private facilities, including out-patient care and rehabilitation treatment and to appropriate $300,000. *APPROVED*

S-902 —To provide that nothing in the act concerning Health Care Facilities Planning Act shall be so construed as a delegation of authority to control charges made by health care facilities for services rendered except as otherwise provided. *APPROVED*

S-903 —To provide that no certificate of need shall be issued or denied without approval of the board and in the event an adverse recommendation has been issued by the State Health Planning Council, the applicant shall receive notice and be granted an opportunity for hearing. *DISAPPROVED,* because this bill would complicate the effective administration of a law that is presently complicated enough.

S-923 —To establish a division of alcoholism in the Department of Health, to create an advisory council, to provide for licensing of alcoholic treatment facilities, to prescribe procedures concerning arrest of an intoxicated person, to authorize establishment of a service force and to repeal and prohibit municipal ordinances prescribing penalties for public intoxication. *APPROVED*

S-932 —To regulate the practice of dentistry. *DISAPPROVED,* because it would impose excessive powers in the Board of Dentistry and would enable them to set up broad and oppressively detailed bureaucratic regulations which would prohibit or unduly limit the licensed practitioner's right to exercise and be guided by his own best professional judgment.

S-934 —To permit pharmacists to use discounts or rebates in sales of drugs or medications to disabled persons or those 65 years of age or older. *APPROVED*

S-936 —To create a guaranteed medical education loan program within the Higher Education Assistance Authority and to appropriate $50,000. *APPROVED*

S-953 —To provide that it shall not be necessary for a physician to be present on premises during the bleeding of a donor of blood at a mobile bank provided the physician will arrive within 15 minutes of a call for assistance. *APPROVED*

Note: The Board changed the Council's position of "disapproved because a physician should be in attendance" to "approved."

S-989 —To provide for the establishment of day care centers and services for the elderly. *APPROVED*

S-997 —To provide that any person who smokes a lighted cigar, cigarette or tobacco in any form in any public meeting room, elevator, theater, public library, or museum where smoking is prohibited shall be a disorderly person. *APPROVED*

S-1003 —To require continuing education for registered optometrists in order to qualify for renewal certificates of registration. *NO ACTION*

S-1004 —To establish a New Jersey Property-Liability Insurance Guaranty Association Act to avoid financial loss to policyholders because of insolvency of an insurer. *APPROVED.* LAW c. 17 (1974)

S-1021 —To prohibit the Department of Environmental Protection and the Commissioner from making any rule or regulation directing mandatory fluoridation of a public potable water supply or adjusting the fluoride content. *DISAPPROVED,* because MSNJ is in favor of mandatory fluoridation as a public health measure.

S-1032 —To establish a Mental Treatment Standards Committee and Patient Treatment Review Board in the Department of Institutions and Agencies. *ACTION DEFERRED,* pending an opinion from the Council on Mental Health.

S-1033 —To provide for the employment of patients in facilities for the mentally ill and in State and county residential services for the mentally retarded. *ACTION DEFERRED,* pending an opinion from the Council on Mental Health.

S-1034 —To provide that the Department of Institutions and Agencies shall establish a method for determining ability to pay for services for the mentally ill and the commitment of the mentally ill and to provide that the Department in cooperation with the county adjuster shall arrange for commitment hearings. *ACTION DEFERRED,* pending an opinion from the Council on Mental Health.

S-1038 —To require a chiropractor using vibratory, massage, traction, diathermy, ultrasound, or other mechanical instruments to be registered as a physical therapist. *APPROVED*

S-1051 —To extend immunity and non-disclosure provisions for medical audit, tissue and mortality review committees. *APPROVED*

A-168 —To require, in place of permit, employment of an optometrist as school vision examiner and a physician to be known as school hearing examiner. *DISAPPROVED,* because the school physician already has the obligation to screen for physical defects, including impairment of vision. The additional requirement of an optometrist or a physician licensed to practice medicine in the State of New Jersey would, in consequence, be an unjustifiable and expensive redundancy.

A-397 —To provide that an act to cause miscarriage of a pregnant woman is justifiable when committed with her consent by a duly licensed physician acting within 24 weeks of the beginning of the pregnancy or under a reasonable belief such is necessary to preserve her life. *DISAPPROVED,* as written, because the bill is not compatible with the following official position of The Medical Society of New Jersey adopted by the House of Delegates in May 1972:

(a) That there be no restriction upon the performance of abortion up to the end of the 16th week from commencement of pregnancy, except those of good, safe, medical practice.

(b) That the requirements for the performance of abortion be: (1) that the pregnant woman gives her consent; (2) that, if married, her husband either concur or sign a release; (3) that her physician agree that her health would safely permit it, or state that her physical or mental health requires it.

(c) A pregnant woman, age 18 or over, should not be required to obtain parental or guardian consent for abortion.

(d) Pregnant girls under age 18 should have parental or guardian consent for abortion.

(e) Abortions should be performed only in those areas of hospitals where adequate surgical practice can be assured by competent medical personnel.

(f) No physician shall be required to perform an abortion, nor shall any institution be required to allow an abortion to be performed within its walls.

(g) No physician or medical institution can be declared liable for having performed an abortion provided that appropriate written permission was obtained and the procedure was done according to accepted standards.

(h) No abortion shall be permitted in New Jersey on any woman who is not a bona fide resident of the State.

(i) No advertising or solicitation of patients for abortions, by direct or indirect methods, in or outside the State of New Jersey, shall be permitted.

A-520 —To create a State Board of Acupuncture in the Division of Consumer Affairs to regulate the practice of acupuncture and the licensing thereof. *DISAPPROVED,* in favor of approval of S-835.

A-588 —To provide for an examination of members of the police department before appointment thereto by a licensed practicing psychologist. *ACTION DEFERRED,* pending an opinion from the Council on Mental Health.

A-613 —To establish a division of alcoholism in the Department of Health, providing for a director and assistant to the director thereof, creating an advisory council on alcoholism, providing for the licensing of alcoholic treatment facilities, prescribing procedures to be followed concerning the arrest of an intoxicated person, authorizing the establishment of a service force, prohibiting and repealing county and muncipal ordinances and resolutions prescribing penalties for public intoxication. *APPROVED*

A-886 —To increase weekly maximum workmen's compensation benefits for permanent partial disabilities to 2/3 of average weekly wages of employees covered by the unemployment compensation law, to increase funeral allowances, to require free choice of physicians, to establish a Workmen's Compensation Board of Appeals and other changes. *APPROVED*

A-1014—To repeal R.S. 45:14-16 which requires that a pharmacy prescription be strictly followed when it is being compounded, filled, dispensed or sold. *ACTIVE OPPOSITION,* because it interferes with the practice of medicine and the physician-patient relationship. The physician and not the pharmacist is responsible for diagnosis and treatment.

A-1182—To prohibit use of Medicaid funds for abortional services except where a mother's life must be preserved. *DISAPPROVED,* because this bill, as written, is not in conformity with MSNJ's official position on abortion and because Medicaid patients are entitled to the same quality of health care.

A-1257—To require pharmacists to list drugs and medicines by generic names and permit them to substitute brand names for the same prescribed named drug with the notification of the doctor if it reflects a lower cost to the consumer. *ACTIVE OPPOSITION,* as written. The Council directed that a conference with the sponsors of the bill be held to seek satisfactory amendments.

A-1284—To redefine various terms with respect to the practice of nursing. *CONDITIONALLY APPROVED,* provided the following language is added to the bill:

This act in no way authorizes nurses to practice medicine except as provided in R.S. 45:9-21 (k).

A-1294—To permit hospitals or other health care facilities to refuse or to allow performance or participation in abortions. *APPROVED*

A-1311—To provide that no person shall advertise or or sell any drug, compound, or medicine without disclosing on the label of the package or bottle the generic and brand name, to permit omitting the generic or brand name if the physician explicitly states on the prescription that no identifying names should be used. *APPROVED*

A-1332—To provide that unless the prescriber explicitly specifies a brand name the pharmacist may dispense the same drug under its generic name if it reflects a lower cost to the customer. *APPROVED*

A-1343—To provide that no dentist and no professional dental service corporation shall charge a patient an extra fee for services in completing a dental claim form in connection with a health insurance policy. *NO ACTION*

A-1375—To provide that the consent to medical or surgical care by a physician or to services by a public or private hospital or public clinic by a person 18 years or more of age shall be valid and binding. *APPROVED*

A-1390—To provide that any person who operates a motor vehicle shall be deemed to have given his consent to the taking of blood and urine samples for determining the content of drugs in his system. *APPROVED*

A-1443—To provide for a New Jersey Property-Liability Insurance Guaranty Association Act to avoid financial loss to policy holders and claimants because of insolvency of an insurer. *APPROVED*

A-1450—To provide for a binding referendum to ascertain preference of voters for mandatory fluoridation of potable water supplies. *DISAPPROVED,* because MSNJ is in favor of mandatory fluoridation as a public health measure.

A-1464—To establish requirements for receiving a first aid or rescue squad member's certificate. *NO ACTION*

A-1501—To provide that hospital service corporation family type contracts for services applicable to children shall be payable with respect to a newly born child of the subscriber or his or her spouse from the moment of birth. *APPROVED*

A-1502—To provide that medical service corporation family type contracts for services applicable to children shall be payable with respect to a newly born child of the subscriber or his or her spouse from the moment of birth. *APPROVED*

A-1503—To provide that health insurance policy coverage for a family member or dependent on an expense incurred basis shall also provide that benefits applicable for children shall be payable with respect to a newly born child of the insured from the moment of birth. *APPROVED*

A-1523—To provide immunity to county and municipal hospitals up to $10,000 of damages for negligence. *APPROVED*

A-1528—To require the separation of solid waste according to food wastes, paper and similar combustibles, glass, metals and other noncombustibles under regulations for disposal prescribed by the Commissioner of Environmental Protection. *NO ACTION*

Filed (page Tr 145)

Incoming President Rogers accepts President's Certificate from outgoing President Boylan.

Administrative Council

Medical Services

Louis K. Collins, M.D., Chairman, Glassboro
(Reference Committee "F")

The Council is charged with the responsibility of studying and evaluating matters relevant to the maintenance and advancement of the standards and character of medical practice in New Jersey, and the investigation of the economic and social aspects of medical care.

Format of Payment Vouchers Under Medicare

The intent of Resolution #12 is to request Prudential Insurance Company to improve methods for the submission of individual "Explanation of Benefits" data for each patient. Since January 1, 1974, Prudential has been sending tapes for Medicare vouchers to Blue Shield in this regard. Physicians will not have to fill out additional forms as they will be automatically reimbursed.

Public Knowledge

Resolution #14 was postponed indefinitely by the 1973 House of Delegates and referred to the Council. The Council disagreed with the intent of this resolution that fee schedules be public knowledge and that it is in the public interest that the finances of the health insurance carriers be open to public scrutiny. After discussion and deliberation, the Council recommended to the Board of Trustees that Resolution #14—Public Knowledge—was impracticable for implementation and requested that the Bergen County Medical Society be informed of this decision. On this item at least the following was accomplished: Prudential released first to The Medical Society of New Jersey and later to the press, a list of unadjusted prevailing fees in the eight areas of New Jersey for four categories of physicians: a) specialists, b) non-specialists, c) internists, d) anesthesiologists, for twenty-five different diagnoses.

Health Insurance Carriers

The 1973 House of Delegates referred Resolution #15 to the Council. The Council members were informed that the Prudential Insurance Company, in refusing certain Medicare reimbursements, has used the terminology "not medically necessary." Medicare has sent out instructions to all Part B Carriers to drop such terms as "reasonable" and "allowable" in regard to fees. Now the only reasonable and allowable term is "amount approved." The following recommendation was approved by the Board of Trustees: It is the decision of the Council on Medical Services that the intent of Resolution #15 "Health Insurance Carriers" will be resolved through both Medicare and the New Jersey Foundation for Health Care Evaluation and that further action is therefore unnecessary.

Control of the Sale of Certain Drugs

Resolution #21 was referred to Council by the 1973 House of Delegates. The Board of Trustees approved the following Council recommendation: That The Medical Society of New Jersey go on record as supporting the Proposed New Rules of the New Jersey State Board of Pharmacy as stated in Resolution #21—Control of the Sale of Certain Drugs—from the 1973 House of Delegates.

Uniform Terminology Project

The Project was completed this year, and Council received copies of the Summary Report of Survey of New Jersey Physicians, prepared by Moshman Associates, Inc.

Prevailing Fee Areas from Eight to Three

The Council recommended to the Board of

Trustees and the Board approved a proposal to reduce the number of Prevailing Fee Areas from eight to three. The over-all effect of this proposal is an increase in prevailing fees in the southern and northwestern areas of the State. Other advantages are: 1) larger data base for each procedure and specialty group, ergo, more accurate information and 2) eliminates demographic inequities (Camden and Atlantic City) and is more reflective of the socio-economic conditions. This applies to Medicare and Medicaid.

AMA Claim Form

The Council reviewed copies of the Health Insurance Claim Form approved by the AMA Council on Medical Services. Prudential would like to conduct a trial study in three counties using the form only for Medicare and Medicaid patients. The Council recommended to the Board of Trustees that The Medical Society of New Jersey authorize Prudential to conduct a pilot study in three counties using the new AMA Claim Form for Medicaid and Medicare patients for a six to nine month period and that Prudential report its results back to the Council on Medical Services. This recommendation was approved by the Board of Trustees. The county societies in the selected areas will, of course, have control over final approval.

Filed (page Tr 147)

House of Delegates—First session

Special Committee to Council on Medical Services

Occupational Health, Workmen's Compensation, and Rehabilitation

Delma W. Caldwell, M.D., Chairman, Linden

(Reference Committee "F")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.

Filed (page Tr 147)

Administrative Council

Mental Health

Robert S. Garber, M.D., Chairman, Belle Mead

(Reference Committee "F")

The Sick Physician—Impairment by Psychiatric Disorders Including Alcoholism and Drug Dependence

The Council was directed to report on "The Sick Physician" as suggested at the 1972 Clinical Convention of the AMA. A Special Committee was appointed and after careful deliberations, a report was submitted to the Board of Trustees on "The Sick Physician—Impairment by Psychiatric Disorders Including Alcoholism and Drug Dependence." A committee from the Council on Mental Health and the Council on Legislation is to be set up to write appropriate legislation to accomplish the purposes contained in the report.

School of Professional Psychology

The Council strongly opposed the establishment of a School of Professional Psychology under the auspices of the CMDNJ, and expressed particular concern over the apparent implication of the endorsement by MSNJ of the independent practice of medicine by non-medical professionals by making this school a component of the medical school. This opinion was presented to the Board of Trustees, who in turn reaffirmed its original position to favor location at CMDNJ rather than at Rutgers since the Board of Higher Education had already decided to establish such a school. In lieu of this, the Council expressed regret over the reaffirmation of the endorsement of a School of Professional Psychology within the College of Medicine and Dentistry of New Jersey, since this would be regarded as tantamount to endorsement of the practice of medicine by non-physicians. Under such circumstances these individuals might well be confused for medical practitioners by our colleagues and the general public. The Council later was officially informed that the School of Professional Psychology will be located at and under the jurisdiction of Rutgers University. The Council was subsequently informed that four degrees will be offered at the Rutgers site—Masters and Doctorate in Mental Health, Doctorate in Mental Health Administration and Ph.D. in Psychology. At this writing the Council has submitted the following to the Board of Trustees for consideration: (1) That MSNJ take active opposition to the granting of the degrees of Doctorate and/or Master in Mental Health, and (2) also opposes the Doctorate in Mental Health Administration being offered by Rutgers University.

Revision of the Medical Practice Act

The matter of unlicensed and unqualified persons practicing psychotherapy was brought before the Council. It was the opinion of the Council that the Medical Practice Act should be revised or at least reviewed as to the sections which pertain to the practice of psychiatry.

After careful consideration the Council reported that violators against the Medical Practice Act are being reported and investigated by the State Board of Medical Examiners and proper action taken. Although the Council is of the opinion that the Act should be revised, such revision does not seem practical at this time.

Acupuncture

The Council determined that acupuncture has yet to be defined—if it is a medical technique and proves to be helpful, then it should be practiced by a licensed physician and not governed by a separate Board and should not be classified as a separate entity. If acupuncture is seen as a non-medical modality, then we have no expertise in this area.

Full-Time Salaried Physicians in Hospitals

It was recommended to the Board of Trustees that the Medical-Hospital Liaison Committee study the relationship between hospital administrators and full-time salaried physicians in hospitals and to establish guidelines for sound interprofessional employment practices for the benefit of the patient. These physicians are under contract and considered as employees of the hospitals, therefore, the hospital representatives would not negotiate the issue. MSNJ will continue to work toward the Council's request to study the relationship between hospital administrators and full-time salaried physicians in hospitals.

Filed (page Tr 147)

Special Committees to Council on Mental Health

Alcoholism

Robert S. Albahary, M.D., Chairman, New Brunswick

(Reference Committee "F")

The Special Committee met regularly and at scheduled times with good attendance. As usual the Committee has discussed various problems connected with care of alcoholic patients in the State of New Jersey. Among others, the following problems were discussed:

1. *Drunk Farms*—Discussion centered about the unlicensed, illegal and unscientific means of treatment of alcoholics at so-called "Drunk Farms." The opinion of the Committee was that these farms should be approved by the New Jersey State Department of Health as far as the treatment modalities were concerned. The Committee was of the opinion that as far as the general public health measures were concerned (fire prevention, kitchen and physical facilities) these were adequate. The Committee feels that a letter should be directed to the Commissioner of Health seeking his opinion on the matter and expressing the Committee's concept of regulating alcoholism facilities along the same lines as those governing drug addiction treatment facilities.

2. *Alcohol Content in Blood*—The Committee noted that in 50 states of the union, all but 6 have set a blood concentration of 0.10 as legal evidence of intoxication. Our state still maintains 0.15. The Committee feels that the state should also adopt 0.10 as legal proof of evidence of alcohol intoxication and understands also that this has been in the legislature but not passed.

3. Upon the recommendation of the Committee there is presently functioning a toll free number at the New Jersey State Department of Health, which serves for all those in need of help, information, and care for alcoholic patients.

4. The Committee has made an inquiry at various component medical societies and found out that only in one society there is an organized committee on alcoholism which seems to be active. The Committee recommends that each of the component county medical societies institute and establish spe-

cial committees on alcoholism, either separate or as a sub-committee of their mental health committees.

Recommendations

1. The Committee again reaffirms its support for the Uniform Alcoholism and Intoxication Treatment Act and recommends its adoption in the New Jersey Legislature. It feels that this is an excellent act and deserves full support of MSNJ.

Approved (page Tr 147)

2. That a uniform alcoholism and intoxication treatment act be recommended for enactment as a law in New Jersey, with the following modification:

> Section 12 (g), Lines 19 to 22 should read "the police or members of the emergency service patrol *or physicians or treatment facility staff,* who act in compliance with this section are acting in the course of their official duty and are not criminally or civilly liable therefor," (Italics indicates addition)

Approved (page Tr 147)

Filed (page Tr 147)

Drug Abuse

Hans W. Freymuth, M.D., Chairman, Trenton

(Reference Committee "F")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.

Filed with notation (page Tr 147)

Emotional Disorders of Childhood and Adolescence

Eugene V. Resnick, M.D., Chairman, Paramus

(Reference Committee "F")

This year the Committee again focused its efforts on working to compile a directory of mental health services in New Jersey. In cooperation with the New Jersey Mental Health Association and with the aid of Bruce H. Medd, M.D., Director of Professional Services of Roche Laboratories, almost all the required data has been collected and organized, ready for publication in booklet form. The Committee anticipates that the directory will be printed within the next few months and will be available for distribution shortly after that to New Jersey physicians and to other interested individuals and institutions.

The Committee also met with an official of the Boy Scouts of America and reviewed with him plans for his organization to develop a health education program under a grant from the Robert Wood Johnson Foundation. The Committee was able to make some comment on the mental health aspects of this program and to suggest names of psychiatrists knowledgeable in this area to serve on the planning committees being formed.

Filed (page Tr 147)

Mental Retardation

Miles E. Drake, M.D., Chairman, Vineland

(Reference Committee "F")

This year the impossible was finally attained. A combined meeting with Dr. Kott, Arnold Kallen, M.D., Theodore Kushnick, M.D., Larry Taft, and myself is scheduled sometime in April for a discussion concerning a Diagnostic Center for the Mentally Retarded in the State. This meeting represents the members of Institutions and Agencies, Rutgers Medical School and the Mental Health Council. It is hoped that we can, within the next year, bring to fruition this most needed service. Who operates the center is not important; but it is important that it be operated.

The committee has not functioned well as a committee this year; only two members were present at each meeting. I have submitted suggestions for committee appointments and hopefully they will prove productive.

Filed (page Tr 147)

Neurological and Related Disorders

J. Lloyd Morrow, M.D., Chairman, Passaic

(Reference Committee "F")

This year the Committee considered the spinal cord injury patient in terms of frequency and facilities for care and rehabilitative management in New Jersey. There are no reliable figures available for the incidence of past cases or for the expectancy of new cases. Local hospitals have made their own arrangements for care and a few centers for long-term rehabilitation carry a heavy burden. Federal funding is provided only for research and pilot programs. The expense of rehabilitative care is staggering. Participation by no-fault insurance plans is hopefully anticipated. The Committee plans to continue its investigation and study of this subject which is of vital importance to the public welfare, with the cooperation of agencies and the specialty societies.

Continuing its interest in the rehabilitation and care of the elderly and brain injured beyond the hospital and at home, the Committee developed a proposal for Local Rehabilitation and Infirmary Units in apartment houses, housing projects, and multiple dwelling units throughout the State. Because of the novelty and technical requirements of such a project, further study is necessary.

The Committee, in pursuing its policy to focus on one major neurologic disorder each year, with a view to better inform the Medical Society and the public, decided upon multiple sclerosis as our topic this year. Emphasis was stressed on the less devastating course and the need for a more hopeful outlook for these patients than is generally believed. Unfortunately, our exhibit for this disorder must await another year, but arrangements are being made for newspaper articles on multiple sclerosis, as well as stroke and epilepsy, previously studied. Our topic for next year will be Parkinsonism.

Filed (page Tr 147)

Administrative Council

Public Health

Robert G. Salasin, M.D., Chairman, North Wildwood

(Reference Committee "G")

The Council on Public Health considered a number of items this year.

Blood Banking

The Board of Trustees referred to the Council on Public Health the opportunity to discuss current activities in the field of blood banking, especially a pilot program to be conducted in Burlington County designated to enable a pledged-donor roster for computerization by the State Department of Health. The Council on Public Health will consider this in the near future when a full report will be made.

Uniform Methods of Screening of Hearing

A recommendation for mandatory methods of screening of hearing in New Jersey schools had been approved by the Special Committee on Conservation of Vision, Hearing, and Speech. This recommendation has been referred to the Council on Legislation for drafting of legislation. The Council approved the concept; however, some of the Council members who are also school physicians have already established rather sophisticated methods of hearing testing in their schools and would like to review any legislation before it is officially adopted by MSNJ.

Child Study Team

The Council discussed the fact that the basic Child Study Team as described under the Beadleston Act does not include a physician. The Council directed that the Special Committee on Child Health discuss the role of a full or part-time physician to be employed as a Consultant to the Department of Education.

Filed (page Tr 149)

Special Committees to Council on Public Health

Cancer Control

Roy T. Forsberg, M.D., Chairman, Elizabeth

(Reference Committee "G")

This year, due to the energy crisis, it was felt that the calling of this Committee from all areas of the state would be unjustified, thus an informal meeting was held with several members of the Committee.

It is now felt that with the formation of the New Jersey Society of Oncology, that increased interest in the field of cancer and its handling will be undertaken by the State Medical Society. It is the feeling of the chairman that this Committee should be a Standing Committee rather than a Subcommittee to the Council on Public Health. It must be recognized that any committee without funding is very inadequate. We are looking forward to increased activity in the year 1974.

Filed (page Tr 149)

Child Health

(Chairmanship Vacant)

(Reference Committee "G")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.

Filed with notation (page Tr 149)

Conservation of Vision, Hearing, and Speech

Alfonse A. Cinotti, M.D., Jersey City

(Reference Committee "G")

The results of the 1973 Eye Health Screening Program reveal that there were 90 participating centers, and that 10,883 persons were screened—6,077 negative; 4,806 positive.

A follow-up of the glaucoma suspects to date has shown that 304 patients have been reviewed either by letter, phone call, or home visits. Of those reviewed 96 were positive for glaucoma and 26 were borderline.

The Committee is actively seeking legislation to provide adequate mandatory methods of the screening of hearing in New Jersey Schools.

Recommendation

That for 1974 the Eye Screening Program be expanded to include the program, "Eye Start" to detect amblyopia, and the distribution of "E" cards and Eye Start pamphlets; and that a pilot project on screening for hearing disabilities also be conducted.

Approved (page Tr 149)

Filed (page Tr 149)

Evironmental Health

Richard H. Musgnug, M.D., Chairman, Haddonfield

(Reference Committee "G")

Although several meetings were attempted in 1973, we were able to get several members together only for a meeting in December. At this meeting it was agreed to poll the absent members regarding their interest in the affairs of the Committee and to seek to invite to membership only those physicians who express an interest in the interests and activities of this Committee.

We have attempted to define the purpose of our Committee as that of an educational one. We hope to increase the awareness of our colleagues in the Medical Society regarding the role environmental pollution plays in the health of themselves and their patients.

Our first project will be to prepare monthly informational articles on environmental health for publication in *The Journal*, MSNJ.

We also hope to send informative bulletins and pamphlets on environmental health to the chairmen of the Committees on Environ-

mental Health in each of the County Medical Societies.

As in the past, the Committee will continue to give testimony at public hearings on matters of interest and concern.

The Committee has also given its unanimous support to Bergen County Medical Society's Energy Crisis resolution with one modifying addition—indicated by italics.

Whereas, the members of the Bergen County Medical Society have labored to improve ambient air quality as a step in enhancing the health of the public; and

Whereas, their efforts aided in the promulgation of codes restricting the level of sulphur in fossil fuels used in New Jersey; and

Whereas, due to the energy crisis, cleaner fuels are in short supply; and

Whereas, critical shortages will still be a problem for some years to come; and

Whereas, we have goodly supplies of high sulphur fossil fuel; and

Whereas, technical equipment has been developed which will remove sulphur from the stack gases and will provide useful by-products such as sulfuric acid and others; and

Whereas, variances are being granted to temporarily use "dirty fuels"; now therefore be it

Resolved, that such variances, if and when granted, be given only when the grantee agrees to the prompt initiation of installation of the best available equipment which will reduce the amount of sulphur and particulates emitted into the air *to levels that will permit the attainment of the national air quality objective now set for 1975.*

We would like to urge the Council on Public Health to endorse this resolution and to send it forward to be endorsed by the House of Delegates.

Filed (page Tr 149)

Maternal and Infant Welfare

Leopold E. Thron, M.D., Chairman, Paterson

(Reference Committee "G")

The Committee reviewed the statistics on maternal deaths during 1973—via mail. There were 20 deaths in New Jersey last year as compared to 38 in 1971, and 22 in 1972.

STANDARDS—OBSTETRICAL DEPARTMENT

The Committee has reviewed the Standards for Obstetrical Departments and has agreed to the deletion of item 4. Along with this, the Committee agreed that the entire Standards be reviewed and revised to take into account the present day practices. The Committee will consider this in the immediate future.

Filed (page Tr 149)

Administrative Council

Public Relations

Howard D. Slobodien, M.D., Chairman, Perth Amboy

(Reference Committee "E")

At the special session of the House of Delegates in December 1972, the Council on Public Relations was directed to accelerate its program. The Council has attempted to secure this mandate by a program of gradual, yet continual, development and expansion. The following lists the fruits of our labors:

1. Continuing projects:

a. Publication and distribution of:

(1) *Junior Health Hints* to schools and public libraries. Series #4 is being revised.

(2) *Membership Newsletter,* including the annual compilation and distribution of a bound, indexed set to component societies. Subtle changes have been introduced in an attempt to make the newsletter more readable and more responsive to the desires of the membership. Additional changes are planned to further this goal.

(3) *Periodic Newsletter* to cooperating agencies/individuals.

b. Preparation and publication of special news releases and publicity as required in furtherance of the Society's business, interests and activities, including:

(1) The Eye Health Screening Program.
(2) The Annual Meeting.
(3) Child Safety Week.
(4) Other selected programs, including diabetes, placement service, immunization, hypertension.

c. Responsibility for bestowal of the Golden Merit Award. The 18th annual bestowal will take place during the second general session of the House of Delegates on Sunday, May 12, 1974. There are 66 prospective recipients. The 1973 Golden Merit Award was given to 55 members of the Society; 31 accepted in person and one was accepted by the physician's son. This brought the total number of recipients since the original presentation in 1957 to 742. The inclusion of the ceremony during the general session of the House received favorable comment and seemed at least partly responsible for an increased attendance in the number of recipients.

d. Responsibility for the informational center and issuance of press releases at the Annual Meeting. The information center will be directed by Martin E. Johnson, our Executive Assistant and Mr. Edward Meara, III, Public Relations Counsel of MSNJ. A review of the results of the 1973 endeavor showed a more favorable reception and a wider dissemination of information throughout the state.

e. Encouragement of continuance or establishment of orientation programs for new members under the sponsorship of component societies.

f. Encouragement of state emergency medical care coverage.

g. Encouragement of Future Physician Clubs.

h. Encouragement of increased voluntary blood donations.

i. Encouragement of radio broadcasts under auspices of component societies.

j. Encouragement of medical TV programs.

k. Continuation of meetings with representatives of the press.

2. Several natural spin-offs from previous activities led to the following:

a. Residents and interns were sent letters of invitation to the Annual Meeting in hopes of promoting future membership.

b. A formal meeting was held with the Woman's Auxiliary to establish support and to request cooperation in the promotion of such valuable programs as Eye Health Screening, Annual Meeting, and so on.

c. We increased our participation in educational programs: Tel-Med, Quality of Life, Medical Care Indoctrination (Rider College) and Drug Abuse lectures at high school and college level.

3. A testimonial dinner was arranged by the Council to honor the retirement of Mr. Richard I. Nevin.

4. The staff of MSNJ was contacted by the Program Director of the N. J. Public Broadcasting System and invited to participate in the TV program "The Killers." This program presented five medical topics from November 1973 to March 1974. A budget of $15,000 was allocated for its support. In addition, publicity was sent to all members of MSNJ, liaison was maintained with the program director and panels of speakers obtained from various areas of the state. Initial feedback suggests we made a wise expenditure of time and money.

5. The responsibility for two additional awards was assumed by the Council:

a. *A. H. Robins Award.* This award is to be given at the Annual Meeting of MSNJ to a New Jersey physician actively engaged in the practice of medicine, for the many and varied services above and beyond the call of duty which he renders to his community. Nominations are to be obtained from the component societies.

b. *The Sheen Awards.* These awards are given annually to an American physician or physicians in recognition of outstanding contributions in medicine. Nominations will be solicited state-wide for consideration of this National award.

6. Three publications were prepared for distribution to the component societies and the membership of MSNJ:

a. *The ABC's of Public Relations.*

b. *The County Medical Society.* This handbook contains information on county society structure and activities and is designed to aid the component society to function more effectively.

c. *Where We Stand.* This booklet, approved by the Board of Trustees, provides the official Society position on many topics, i.e., Abortion, Chiropractic, Drugs, National Health Insurance, and many others.

7. The Board of Trustees discussed the WNBC-TV (Channel 4, N.Y.) broadcast "Medicine—Where Does It Hurt?", aired on Sunday, December 9, 1973 at 10 p.m. There was unanimous agreement that the program presented a slanted and distorted view of medicine and the matter was referred to the Council on Public Relations.

Numerous meetings were held among representatives of the Council, the Board of Trustees, the Medical Society of New York, Lincoln-Mercury (sponsors) and its ad agency, NBC-TV (network) and WNBC-TV. The following represents a capsule view of our progress:

a. The Medical Society of New York is in complete agreement with our position and will support us.

b. The Lincoln-Mercury Division of Ford Motor Company, along with its ad agency, Kenyon and Eckert, has tendered us a letter of apology, withdrawn their advertising contract, censored the station, and invited us to meet with them and WNBC-TV to plan programming for future events more in the interests of both the medical profession and the public.

c. WNBC-TV and NBC-TV have invited us to meet with them. We intend to do so.

d. Other approaches for better relationships with the media were suggested and approved by the Board of Trustees. They are *recommended* to you for implementation:

1. Arrange a meeting with the medical reporters of *The New York Times.*

2. Continue the development of a roster of local and state medical personnel with expertise to be furnished to both local and regional media. This should be maintained and furnished periodically both in and out of state.

3. Attempt to develop programs oriented to New Jersey, perhaps using both MSNJ and CMDNJ as sources.

4. Continue the meetings with state representatives of the media and expand the program to include representation from New York City and Philadelphia.

5. Arrange liaison regarding Public Relations among the Medical Societies of New Jersey, New York City, Connecticut and Philadelphia.

6. Consider giving input to the Sunday morning program of WNBC-TV and to the NBC-TV news programs at dinner time.

The Council wishes to give its heartfelt thanks to each person, whether Trustee or grass-roots member, who stimulated its efforts. We reserve special thanks for the Executive Staff of MSNJ for their zeal in pursuing the objectives of the Council on Public Relations, objectives we hope will reflect the most commendable attitudes of physicians throughout New Jersey.

Filed (page Tr 145)

President-Elect and Mrs. James Rogers

Special Committees

Emergency Medical Care

Jack R. Karel, M.D., Chairman, Hillside

(Reference Committee "D")

Emergency medicine has continued to forge ahead with new and sophisticated programs necessitating constant vigilance. One of the more important requirements is the constant need for continuing medical education for all personnel working in hospital emergency departments and related fields.

To enhance emergency medicine in the nation, Congress enacted Public Law 93-154, known as the Emergency Medical Services Systems Act of 1973, to assist government and non-government public agencies in improving their emergency medical programs.

Hospital Signs

MSNJ continues its emphasis on the placement of hospital signs on major thoroughfares and highways. State and county governments must continue this program to its completion. We hope this program will be completed in 1974.

Emergency Department Medical Technician Program

We have been working toward the development of a two-year hospital emergency department medical technician program since 1972. In a survey conducted by the MSNJ it was determined that New Jersey hospitals will employ these ED EMT's and that there is a guaranteee of a living wage. It has also been determined by Federal officials that such trained individuals are needed and would be employed in Veterans Hospitals. To further this program, the College of Medicine and Dentistry of New Jersey was notified of our program and it was determined that the College would also implement a basic course for EMT's. The end result was a merging of programs for the development and provision of well-trained personnel in the technique and procedures of emergency medical care. This program will provide for an associate degree and has been submitted to the State Department of Higher Education for approval. It creates a career ladder to other medical disciplines. The State Board of Medical Examiners will be requested to provide legal authorization for the employment of these ED EMT's.

The House adopted a recommendation of the Reference Committee that the Committee on Emergency Medical Care explore in depth, with the medical staffs of the various hospitals, the employment possibilities for ED EMT's prior to seeking from the Board of Medical Examiners legal authorization for their employment in the emergency department. (page Tr 144)

State Emergency Medical Service Advisory Council

The Board of Trustees has approved the concept of a Governor's Advisory Council on Emergency Medical Services for the State of New Jersey. Because of the number of medical organizations and other allied medical agencies involved in emergency medicine comprising the Inter-Agency Commission on Emergency Medical Care and its expertise, the Board of Trustees recommends that this Commission represent the Governor as the Advisory Council on Emergency Medical Service for the State of New Jersey.

Emergency Medical Communications

Moratorium on Purchase of Equipment with Federal Funds—In its emergency medical communications survey and study by the Inter-Agency Commission on Emergency Medical Care now under way in the counties, it was brought to the attention of the Special Committee that money is being wasted on ambulance telemetry equipment. Manufacturers of radio-telemetry equipment have not standardized their equipment on the sub carrier frequency for ECG telemetry. This means that no two manufacturers' equipment are

compatible. Frequencies are being established specifically for emergency medical services by the Federal Office of Telecommunications that will take several months to finalize. During this period of time it is recommended that no money be spent on any radio equipment. The Board of Trustees has approved the recommendation to notify the State Office of Highway Safety that no funds for this equipment should be allocated unless that equipment is in accordance with frequencies approved by the Federal Government and are regionalized.

Central Emergency Medical Telephone Number

The Board of Trustees has approved the recommendation of the Special Committee that the concept of an emergency telephone number, such as, 911, or any seven-digit number be established with a central dispatch is essential to a statewide emergency medical care system. In this regard, notification has been made to the Governor of New Jersey, New Jersey Association of Chosen Freeholders, County Boards of Chosen Freeholders, League of Municipalities, and the New Jersey Bell Telephone Company.

Inter-agency Commission on Emergency Medical Care

MSNJ, as the parent organization of the Commission, the latter being composed of all major medical and allied medical organizations involved in emergency medical care, has supported the work of the Commission very closely, and practically on a daily basis. The Commission is now incorporated and a tax-exempt organization. During the past year various projects have been completed, are now under way or are in the planning stage. These projects have been the result of approved grants from the New Jersey Regional Medical Program as follows:

1. $8,900 for an emergency medical communications engineering survey and study for the counties of Hunterdon and Mercer, which have been completed.

2. $23,840 for a Tri-County emergency medical communications engineering survey and study for Union, Essex and Hudson Counties. This is now under way.

3. $15,000 for programing and establishing a data bank for hospital emergency department survey reports and categorization of hospital emergency department capabilities. This is now under way. Also, a statewide conference will be held on the subject of categorization of hospital emergency department capabilities in April 1974.

In addition to the above grants from NJRMP, a grant of $42,000 was approved from the Greater Delaware Valley RMP for the development of EMS Councils for the seven southern counties of New Jersey, an educational program for the public in EMS, an emergency medical educational program for professional and allied professional personnel, and for the printing of 1,000,000 special emergency stickers to be distributed to the homes.

Recommendations

1. A training program for physicians and nurses working in emergency departments sponsored by MSNJ. This program would be held in each of the medical judicial districts in selected hospitals as was conducted in 1970-71 with great success. Lectures would be by physicians in their respective specialties. AMA continuation medical education credit would be requested. Estimated cost for the entire program is $5,000. An application will be submitted to the Division of Emergency Medical Services under PL 93-154, known as Emergency Medical Services Systems Act of 1973, for this particular program. If funding is unavailable, cost would be borne by MSNJ.

Rejected with notation (page Tr 144)

2. The New Jersey Regional Medical Program, which has rendered vital financial and administrative assistance to the Commission from the onset, began its separation from the Commission as of January 1, 1974; to be

completed by June 30, 1974. The Commission will need financial support in the sum of $10,000 after June 30, 1974 to continue its work and supervision of projects under way and others to be formulated, especially, a statewide emergency medical care plan. It is, therefore, recommended that MSNJ continue to support the efforts of the Commission.

Rejected with notation (page Tr 144)
Filed (page Tr 144)

Physicians' Relief Fund

Joseph J. Kline, M.D., Chairman, Trenton

(Reference Committee "B")

The committee had no occasion to meet during the last year. One incomplete application for financial assistance was submitted. Since the potential applicant did not reply to further correspondence, no action was taken by the committee. While it is hoped that the lack of applicants for assistance is a reflection of the financial security of the membership, regular announcements of the availability of such support should be inserted in the State and County medical bulletins.

The financial activities of the Fund during the year are included in the report of the Treasurer.

Filed (page Tr 141)

Project Hope/Vietnam

Thomas C. DeCecio, M.D., Chairman, Cliffside Park

(Reference Committee "B")

No applications were submitted this year to the Committee. Consequently, no meetings were held during the administrative year.

Filed (page Tr 141)

Medicine and Religion

John J. Bedrick, M.D., Chairman, Bayonne

(Reference Committee "D"

The Committee has had no formal meeting this year and thus has no formal report to make to the House.

Filed (page Tr 144)

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "C")

A legislative proposal that would increase the present tax deferral available to the self-employed has not become law as yet. Under consideration by Congress at the present time is a bill which would increase the amount of tax deferral for self-employed pensions from the present $2,500 or 10 percent of income to $7,500 or 15 percent income, whichever is less.

The annual reports from Pro Services, Inc. and the E. & W. Blanksteen Agency follow. Both of these retirement plan offerings are approved by The Medical Society of New Jersey.

HR-10 (Keogh) Variable Annuity Retirement Investment Plan

The Medical Society of New Jersey Retirement Plan Trust A was established by the Society in 1970 to provide for all members of the State Society the Keogh Program of the Prudential Insurance Company of America, featuring the group Fixed-Dollar Annuity and the group Variable Annuity with E. & W. Blanksteen Agency, Inc. as Administrator. This program had originally begun in Essex and Union Counties where it had achieved widespread acceptance by the members.

The program includes three unique advantages in addition to the well-known tax saving and tax shelter features of the Keogh Law:

1. A lifetime monthly variable payout, based on a common-stock portfolio. (The Variable Annuity)

2. A death-benefit guarantee, so that if the participant dies during the accumulation period, his beneficiary will never receive less than the amount the participant has paid in.

3. Flexibility during accumulation years, permitting the allocation and transfer of funds, at your option, to and from the common-stock account and the fixed-dollar account.

Internal Revenue Service approval for the Master Plan (with Serial Number 701115) was received November 30, 1970.

Throughout the state we have 311 plans in effect covering 402 people with $2,293,356 deposited by members of this program since inception.

Corporate Master Retirement Plan

The Society has recognized that some of its members may see fit to practice in the form of a corporation. Therefore, the Committee recommended and the Society approved in 1970, the establishment of The Medical Society of New Jersey Retirement Plan Trust—B, which adopted a Corporate Master Retirement Plan using the same funding agents as the Keogh program described above. This program, in the form of a Master Profit-Sharing Plan permits corporations, one of whose employees is a member of the Society, to place up to 15 percent of payroll in a tax-sheltered program, with the same flexibility and options as our Keogh program using the Prudential Insurance Company's group Fixed-Dollar Annuity and group Variable Annuity. Some of the useful and valuable features of this Master Plan are described below:

1. Eligibility Requirements—Employment 0 to 5 years—Minimum age up to 30

2. Flexible Retirement Date (especially valuable for older corporate officers)

3. Choice of contribution formulas including Social Security integration.

4. Vesting can be as minimal as nothing for the first five years under the plan and then 10 percent a year for the next ten years

This plan is administered by E. & W. Blanksteen Agency, who will be pleased to furnish members with full information concerning this plan which should provide a substantial savings since it is not necessary to have a plan and trust especially drawn for you. Many large corporations and other organizations use these same funding agents for their tax-deferred retirement plan including that of our administrator.

PRO Services Inc.

The following is a progress report on The Medical Society of New Jersey PRO Group Keogh and Professional Corporation Plan approved by the Executive Committee on July 22, 1970.

PRO Services Inc. is a financial service organization plan administrator for the Medical Society PRO Group Retirement Plans. PRO Services Inc. has incorporated a number of substantive changes in their plan which will be of interest to the members.

1. *Sales and Service:* Janney Montgomery Scott Inc., a New York Stock Exchange firm, will act as the sales and service facility for plan participants and prospective enrollees. Janney Montgomery Scott Inc. has offices in Hackensack, East Orange, Toms River, Cherry Hill, and Woodbury, New Jersey which will act as the service and sales facilities. In addition, there will be ten specialists trained in financial and retirement planning to serve plan participants.

2. *Society Liaison & Marketing Management:* PRO Services Inc. has entered into a contract that brings James Castle & John Cannon, two of the founders of PRO Services Inc. back into the PRO family. Messrs. Castle and Cannon will be actively engaged in, and responsible for, the marketing aspects and certain management aspects of the PRO Retirement plans. Jim Castle, as President, will coordinate the marketing and service through Janney Montgomery Scott Inc.

3. *Investment Options to be added:* PRO Services Inc. will introduce three new options for selection by plan participants.

(a) *A no-load Income Fund*—The basic emphasis will be to seek the highest yield in money market securities and high grade equities with very low risk.

(b) *Individual Managed Accounts*—This option will be available to participants with accounts in excess of $50,000 and will enable a physician to tailor his investment account through the selection of securities with a portfolio manager.

(c) *Savings Account Option*—Provisions are being made to permit participants the use of a saving option with the Trustee Bank.

For those members who wish additional information, representatives will be at the PRO and Janney Montgomery Scott booth during the annual meeting or you may contact members of the Retirement Plan Committee.

Filed (page Tr 142)

From the left—Mr. Sullivan, AMA staff; Mrs. Lucci; Mr. Lucci, Executive Assistant; Mrs. Maressa; Dr. Mineur; Mr. Maressa, Executive Director.

Medical-Surgical Plan of New Jersey

Joseph P. Donnelly, M.D., President, Newark

(Reference Committee "C")

People helping people. That's what Blue Shield is all about.

Responding to Human Needs

Acting in concert with The Medical Society of New Jersey to render service to mankind. Working with our participating physicians to help people to obtain private, personal medical care at a premium they can afford.

People helping people. Board members giving time without pay and Blue Shield management planning new programs which will make it possible for New Jerseyans to continue to receive benefits of quality medical care at a price they can afford.

Participating physicians accepting a usual, customary, or reasonable fee which is established by themselves and their peers as payment-in-full for their services under the Prevailing Fee program. All physicians filing claims so that Blue Shield can make prompt payment for services rendered to patients.

All of us responding to human needs.

In 1973, Blue Shield of New Jersey strengthened its efforts to be responsive to the needs of its subscribers and its providers. It was a year in which we endeavored to determine current people-needs and meet those needs.

Demonstrating our responsiveness and concern were these events:

We introduced a new higher-payment fixed-fee program more in tune with the times. This is the 750 Series which provides payments some 45 percent above the 500 Series. We felt it was time to do this—both for the participating physicians who have been accepting less than usual payments as payment-in-full for low-income subscribers, and for over-income subscribers who were willing to pay a higher premium in order to have a larger portion of their eligible doctor bills covered. We are happy to report that this program has been well accepted. At year-end the 750 Series covered more than 55,000 members.

The income limits for "service benefits" under this program are $7,500 for single subscribers and $12,000 for families. At year-end there were almost 9,000 participating physicians in our fixed-fee programs.

During the year we made our greatest efforts to sell the Prevailing Fee Program, which is best for the physician as well as the subscriber, and is growing rapidly. Physician participation was almost 7,500.

Effecting gains in this program is a two-way street. The more physicians participate, the easier it is for us to enroll more subscribers. And, conversely, the more subscribers we have, the better it is for the physicians. Large companies, unions and small groups would be much more apt to purchase the program for their employees if participation by physicians were at 90 percent instead of 67 percent. And employees would be more likely to demand the program under those circumstances.

There are other benefits for physicians in participating in Prevailing Fee. These are: reimbursement at your usual, customary, or reasonable fee; payment is sent directly to you; no patient billing is necessary; you are not limited to an unchanging fixed-fee program; and it will be better for patients, since they will have no balance bill to pay.

You may be interested to know that no one dropped the Prevailing Fee Program for the 750 Series, as a few people had feared. What seems to be developing is a continuing upward trend. Managements and unions which had purchased the 500 Series for their employees are moving to the 750 Series with

anticipation of a second jump to the Prevailing Fee program. We predict a steady flow from the 500 to the 750 Series and a rapid growth of Prevailing Fee from both of these fixed-fee programs. We are hopeful that we may be able to drop the 500 Series within a few years because the 750 Series is more equitable and appropriate and we believe the Prevailing Fee program is our best.

The future of Blue Shield, and more important the future of the private practice of medicine, depends to a large degree on the acceptance of a prevailing fee program by the profession.

It is my opinion that medicine's right to establish and maintain equitable and appropriate fees in a voluntary prepayment program will be preserved only so long as the profession maintains its own self-imposed discipline. The price of freedom is the acceptance of reasonable self discipline.

In another important move to help subscribers and physicians, Blue Shield of New Jersey made some 500 selected upward revisions in the 500 Series for infrequently performed procedures and then made a five percent across-the-board increase in the entire program on top of that effective April 1. The upward revisions meant that there was an average increase of 10 percent in the payments for physicians' services under the 500 Program.

We also have moved promptly to accept proven new procedures and techniques made possible by advancement in the science of medicine. We will continue to follow that course.

We were able to assist our over-65 subscribers, starting in 1973, by picking up the $10 increase in Medicare deductible. This made our complementary program more responsive to the needs of retired persons living on small fixed incomes where every dollar counts.

For New Jerseyans with health problems, who previously could not obtain health insurance, Blue Shield, with Blue Cross of New Jersey, held a one-month open enrollment period on the recommendation of the Insurance Commissioner. These subscribers are to be covered for all eligible services with the exception of their pre-existing conditions during the first year of enrollment and after that period without restriction.

On the recommendation of the state's Insurance Commissioner, we granted a 10 percent premium reduction to some 540,000 community-rated subscribers. This was a response to the year-end 1972 reserve of almost $20 million.

That reserve dwindled by more than $5 million during 1973 and we ended that year with a reserve of under $15 million. We expect the downward trend to continue during 1974. The almost $15 million reserve amounts to only $3.40 per member.

Changing times create new requisites. The mood of the land now is for more consumer participation. And so in 1973, for the first time in our 31-year history, we moved to a position where we had more laymen than physicians on our board of trustees. During the previous six years three representatives of labor had joined our board. In 1973, we added two women to the board, both of whom are mothers and working women well aware of family health-care needs. A young college administrator who is responsible for student aid at a state college also was added to the board. As the father of two infants, he understands the necessity for adequate healthcare coverage. Our board composition in 1973 became 18 laymen and 15 physicians.

The services of the 15 physician members of the board continue to be of the greatest value because their professional knowledge is needed on committees such as the Medical Policy and Fee Committee and the Physicians' Review Committee. Their concern for patients is reflected in their board actions. All board members serve without pay, and in addition to regular monthly board meetings they are

present at committee meetings and are available for consultation whenever they are needed.

At this time we wish to thank the many physicians throughout New Jersey who from time to time are consulted informally by our medical staff and who freely offer invaluable assistance.

Claims incurred were more than $111 million in 1973, up from about $89 million in 1972, an increase of $22 million.

Our membership grew by some 158,000 to about 3,900,000 to cover more than 52 percent of the state's population.

We're proud of our growth during 1973, but we're really happiest about the things the physicians of New Jersey and Blue Shield were able to do for people in helping them to obtain, and afford, private medical care, including a free choice of physician and a close doctor-patient relationship.

Other Highlights of 1973

- The New Jersey Dental Service Plan completed its third full year of operation with nearly a 90 percent increase in enrollment. At the end of 1973, membership was over 80,000 persons, enrolled through 68 groups. More than 17,000 claims were paid during the year, and more than $1.4 million in benefits were incurred. More than 82 percent of the state's dentists were participating in the program at year-end.

- Mercer Medigroup, the state's first health maintenance organization, was begun in Trenton in response to physician and subscriber interest as an alternative to traditional Blue Cross-Blue Shield coverage. By the end of the year it was serving 2,200 members.

- A health education program concerning drug abuse, alcoholism, and suicide was continued.

- A series of stories designed to improve knowledge of Blue Shield programs was sent to daily and weekly newspapers throughout the state.

- A new Blue Shield advertising campaign featuring patient stories was inaugurated. A joint advertising campaign with Blue Cross of New Jersey was continued.

- Blue Shield of New Jersey paid claims totaling $1,772,861 for The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

- Total membership reached 3,880,319, an increase of 158,152, or 4.2 percent in 1973, covering more than 52 percent of the population of New Jersey.

- Total number of groups enrolled increased by 891, to 19,109.

- Prevailing Fee membership grew by 161,107 to 639,196, a 33.7 percent increase.

- There were 55,112 persons enrolled in the new 750 Series.

- Nearly 10,000 persons enrolled during the Open Enrollment period.

- The over-65 program grew by 16,183 to 186,661, or which 77 percent have the Extended Benefits Rider.

- There were 132,512 persons enrolled under the Federal Employee Program. Claims paid amounted to $5,447,638.

Physician Relations

Ever since our early days, we have had a program called Physician Relations, which is intended to provide continuing two-way communication between the doctors and ourselves. We view this as another people helping people program as it is a sincere effort on our part not only to give information, but to listen to the needs of our providers.

During 1973, our Physician Relations Field

Representatives made 1,119 personal visits to physicians' offices, primarily at physicians' requests, providing service to 5,307 physicians. These were times for the asking and answering of questions—and the most frequent subjects were the Prevailing Fee and 750 Series Programs.

In addition, in 1973 the field representatives held 93 meetings with paramedical assistants as well as 30 meetings in hospitals with physicians.

Our Physicians' Inquiry Unit answered about 43,000 telephone inquiries and more than 68,000 written inquiries.

Our Prevailing Fee Unit handled about 9,500 cases dealing with the maintenance and control of computer profiles.

The Physicians' Record Unit processed more than 7,000 changes to our provider records.

Members of the Physician Relations Section would like to take this opportunity to thank our participating physicians for their cooperation, loyalty, and dedication and to thank all the physicians of New Jersey for their services to Blue Shield subscribers.

Utilization Review

"A most exciting and rewarding year." Those are the words of the manager of a program we call Utilization Review, the purpose of which is to work with physicians, subscribers, paramedical personnel, and those responsible for enrolled groups to conserve the healthcare dollar.

We have been able to effect real savings for our subscribers through: an educational poster program; flip chart presentations to chapters of the American Association of Medical Assistants and to enrolled groups; an on-going prepayment review of Rider J services; continuing postpayment reviews sometimes including personal visits to physicians; visits to government health facilities; postpayment audits through hospital charts; participation in Regional meetings for an exchange of information with other plans.

It has been possible to document savings of $670,000 in 1973 through prepayment reviews alone and some $61,000 was refunded by 159 physicians.

The deterrent effect of the audits and reviews, we are sure, conserves many more healthcare dollars. As the medical profession and the general public are made aware of our program of prevention, detection, and elimination of payment for ineligible services under terms of our contracts, its effectiveness is strengthened.

During 1973, 151 routine, at-random postpayment audits were made with medical records in hospitals, as well as 47 special audits.

The educational posters, with the theme "Use your benefits—don't abuse them," were sent to 1,800 enrolled groups for display on employee bulletin boards. More than 8,000 such posters, demonstrating our concern over healthcare costs, were distributed.

In late year, a program of personal visitation by a Plan Physician-Medical Advisor and a utilization analyst to physicians where misunderstanding, overuse or abuse was apparent, was started. In each of the 26 visits cooperation was forthcoming, and, later reviews indicated, was continued.

Annual Statistics

Table 1

Distribution of All Underwritten Services and Payments made in 1973

Type of Service	Total Services	% All Services	Payment	Percent	Payment Per Service
Surgical	815,338	32.7	$48,321,193	48.5	$ 59.27
Medical	1,359,972	54.5	31,732,909	31.9	23.33*
Obstetrical	44,038	1.8	8,864,263	8.9	201.29
Consultation	79,216	3.2	1,845,140	1.8	23.29
Anesthesia	195,082	7.8	8,839,122	8.9	45.31
Total	2,493,646	100.0	$99,602,627	100.0	$ 39.94

*Includes laboratory, x-ray, physical therapy etc.

Table II

Distribution of Community Rated Rider Services and Payments made in 1973

Type of Service	Total Services	% All Services	Payment	Per-cent	Payment Per Service
Surgical	73,425	15.4	$1,397,698	20.1	$ 19.04
Medical	3,728	.8	222,853	3.2	59.78
Diag. X-Ray	184,277	38.7	3,183,858	45.8	17.28
X-Ray Therapy	893	.2	140,963	2.0	157.85
Physical Therapy	8,895	1.9	182,566	2.6	20.52
Pathology	204,962	43.0	1,828,395	26.3	8.92
Total	476,180	100.0	$6,956,333	100.0	$ 14.61

Table III

Distribution of Earned Subscription Income

Earned Subscription Income	$116,539,539	100%
Incurred Claims	111,231,760	95.4
Surgical		46.3
Medical		30.4
Obstetrical		8.5
Anesthesia		8.5
Consultations		1.7
Operating Expense	14,131,819	12.1
Underwriting Gain (Loss)	($8,824,040)	(7.5)

Summary of Operations 1973

Incidence Rate— Cases per 1000 Persons Enrolled	438

Comparative Balance Sheet—December 31, 1973

Assets	*1973*	*1972*
Investments		
Accounts Receivable	$43,231,807	$43,453,102
Subscriber Premiums	3,485,500	2,144,368
National Account Program	6,918,534	4,818,529
Federal Employee Program	1,991,944	1,773,100
Miscellaneous	383,515	121,421
Accrued Income on Investments	709,646	660,637
Total Assets	$56,720,946	$52,971,157

Liabilities	*1973*	*1972*
Provision for Medical and Surgical Claims	$27,702,000	$21,593,000
Excess of Outstanding Checks over Balance in Bank Accounts	1,883,994	1,222,599
Unearned Subscription Income	5,259,004	4,247,819
Accounts Payable—Miscellaneous	2,815,356	2,629,362
Reserve for Group Contract Settlement	2,682,026	1,915,999
Deposits from Organizations	1,566,349	1,475,154
Total Liabilities	$41,908,729	$33,083,933

Reserves for Protection of Subscribers	*1973*	*1972*
General Reserve	$ 100,000	$ 100,000
Securities Evaluation	1,319,944	1,331,650
Unassigned	13,392,273	18,455,574
Total Reserves	$14,812,217	$19,887,224
Total Liabilities and Reserves	$56,720,946	$52,971,157

Comparative Statement of Operations

		1973			*1972*	
Subscriptions Earned		$116,539,539	100.0%		$109,123,720	100.0%
Less:						
Claims Incurred	$111,231,760		95.5	$88,936,209		81.5
Operating Expenses	14,131,819		12.1	13,090,531		12.0
		125,363,579	107.6		102,026,740	93.5
Gain from Underwriting Operations		(8,824,040)	(7.6)		7,096,980	6.5
Income on Investments		2,606,830	2.3		2,198,194	2.0
Operating Gain or (Loss) for the Year		$ (6,217,210)	(5.3) %		$ 9,295,174	8.5%

Statement of Reserves for Protection of Subscribers

		1973		*1972*
Reserves at beginning of Year		$19,887,224		$11,451,445
Operating Gain or (Loss) for the Year		(6,217,210)		9,295,174
		13,670,014		20,746,619
Reserves Adjustment:				
Non-Admitted Assets	$1,356,038		$ (1,142,987)	
Unrealized Capital Gain or (Loss)	(340,799)		274,076	
Miscellaneous	126,964	1,142,203	9,516	(859,395)
Reserves at end of Year		$14,812,217		$19,887,224

New Jersey Participating and Non-Participating Physicians by County—Prevailing Fee Program

County	Total Elig. Phys.	PARTICIPATING					NON-PARTICIPATING					% P.P. as of 12-31-73	% P.P. as of 12-31-72
		Total	M.D.	D.O.	D.P.M.	Lab.	Total	M.D.	D.O.	D.P.M	Lab.		
Atlantic	307	262	232	14	13	3	45	39	2	3	1	85.3	82.3
Bergen	1407	649	557	55	26	11	758	712	25	15	6	46.1	49.5
Burlington	346	261	206	43	10	2	85	77	4	4		75.4	75.2
Camden	893	716	488	187	35	6	177	138	30	7	2	80.1	76.5
Cape May	79	59	46	9	3	1	20	15	5			74.6	73.3
Cumberland	154	125	109	8	5	3	29	25	3	1		81.1	80.4
Essex	1815	1219	1128	33	48	10	596	565	14	14	3	67.1	67.9
Gloucester	179	136	93	31	10	2	43	36	6		1	75.9	75.0
Hudson	793	554	506	15	28	5	239	223	6	6	4	69.8	70.3
Hunterdon	76	58	58				18	18				76.3	80.0
Mercer	621	433	395	16	18	4	188	181	5	2		69.7	71.8
Middlesex	668	405	366	16	14	9	263	248	7	3	5	60.6	64.2
Monmouth	671	407	380	15	11	1	264	247	10	5	2	60.6	62.9
Morris	566	382	350	19	7	6	184	173	8	3		67.5	68.7
Ocean	285	159	137	16	5	1	126	112	10	2	2	55.8	60.0
Passaic	747	485	430	30	21	4	262	244	5	9	4	64.9	64.7
Salem	60	51	43	5	2	1	9	7	2			85.0	81.3
Somerset	260	185	173	5	5	2	75	73	1	1		71.1	72.9
Sussex	88	68	63	4	1		20	17	2		1	77.2	77.2
Union	933	555	473	50	27	5	378	351	13	11	3	59.4	60.0
Warren	68	55	52	1		2	13	11	1	1		80.8	83.5
Out of State	279	145	118	22	5		134	116	16	1	1	51.9	50.9
Total	11295	7369	6403	594	294	78	3926	3628	175	88	35	65.2	66.1

New Jersey Participating and Non-Participating Physicians by Specialty—Prevailing Fee Program

Specialty													
Anes.	544	338	319	19			206	199	7			62.1	60.3
Derm. Syph.	193	106	105	1			87	87				54.9	56.4
Int. Med.	1793	1155	1122	33			638	630	8			64.4	65.8
Neur. Surg.	103	51	51				52	52				49.5	56.5
Obst.-Gyn.	867	608	589	19			259	256	3			70.1	71.2
Ophth.	405	225	223	2			180	177	3			55.5	58.3
Orth. Surg.	405	203	195	8			202	201	1			50.1	52.5
Otol.	249	133	128	5			116	114	2			53.4	53.7
Path.	219	128	126	2			91	87	4			58.4	58.4
Ped.	689	464	457	7			225	224	1			67.3	67.9
Phys. Med.	35	21	20	1			14	13	1			60.0	60.0
Plast. Surg.	66	17	16	1			49	49				25.7	29.6
Analy. Labs.	113	78				78	35				35	69.0	67.4
Proct.	41	25	20	5			16	15	1			60.9	70.0
Psy. & Neuro.	612	368	361	7			244	244				60.1	60.3
Radiology	382	244	233	11			138	134	4			63.8	62.8
Surg.	1080	721	692	29			359	357	2			66.7	67.1
Thor. Surg.	68	38	38				30	30				55.8	55.9
Urol.	277	152	147	5			125	125				54.8	57.5
Podiatry	382	294			294		88			88		76.9	76.8
General	2772	2000	1561	439			772	634	138			72.1	72.0
Total	11295	7369	6403	594	294	78	3926	3628	175	88	35	65.2	66.1

New Jersey Participating and Non-Participating Physicians by County—Basic Program

County	Total Elig. Phys.	PARTICIPATING Total	M.D.	D.O.	D.P.M.	Lab.	NON-PARTICIPATING Total	M.D.	D.O.	D.P.M	Lab.	% P.P. as of 12-31-73	% P.P. as of 12-31-72
Atlantic	307	301	265	16	16	4	6	6				98.0	97.6
Bergen	1407	771	655	67	34	15	636	614	13	7	2	54.8	59.3
Burlington	346	328	266	46	14	2	18	17	1			94.8	92.0
Camden	893	796	537	213	39	7	97	89	4	3	1	89.1	88.7
Cape May	79	78	60	14	3	1	1	1				98.7	97.3
Cumberland	154	145	126	10	6	3	9	8	1			94.1	93.4
Essex	1815	1451	1336	42	62	11	364	357	5		2	79.9	81.1
Gloucester	179	159	111	35	10	3	20	18	2			88.8	88.9
Hudson	793	671	611	19	33	8	122	118	2	1	1	84.6	84.4
Hunterdon	76	70	70				6	6				92.1	93.3
Mercer	621	491	449	18	20	4	130	127	3			79.0	80.8
Middlesex	668	488	442	20	15	11	180	172	3	2	3	73.0	75.9
Monmouth	671	501	464	20	14	3	170	163	5	2		74.6	73.8
Morris	566	469	431	23	9	6	97	92	4	1		82.8	82.8
Ocean	285	180	154	18	6	2	105	95	8	1	1	63.1	70.1
Passaic	747	566	497	34	28	7	181	177	1	2	1	75.7	75.6
Salem	60	57	48	6	2	1	3	2	1			95.0	93.2
Somerset	260	223	211	5	5	2	37	35	1	1		85.7	86.2
Sussex	88	84	76	6	1	1	4	4				95.4	95.4
Union	933	703	597	61	37	8	230	227	2	1		75.3	76.2
Warren	68	61	56	2	1	2	7	7				89.7	91.0
Out of State	279	266	221	38	6	1	13	13				95.3	94.9
Total	11295	8859	7683	713	361	102	2436	2348	56	21	11	78.4	79.5

New Jersey Participating and Non-Participating Physicians by Specialty—Basic Program

Specialty													
Anes.	544	308	286	22			236	232	4			56.6	55.3
Derm. Syph.	193	126	125	1			67	67				65.3	66.6
Int. Med.	1793	1340	1299	41			453	453				74.7	75.5
Neur. Sur.	103	67	67				36	36				65.0	69.5
Obst.-Gyn.	867	679	659	20			188	186	2			78.3	79.2
Ophth.	405	253	248	5			152	152				62.4	64.3
Orth. Surg.	405	272	264	8			133	132	1			67.1	69.2
Otol.	249	164	158	6			85	84	1			65.8	68.0
Path.	219	179	174	5			40	39	1			81.7	82.2
Ped.	689	605	597	8			84	84				87.8	88.3
Phys. Med.	35	28	26	2			7	7				80.0	86.6
Plast. Surg.	66	26	25	1			40	40				39.3	44.4
Analy. Labs.	113	102				102	11				11	90.2	89.4
Proct.	41	20	14	6			21	21				48.7	52.5
Psy. & Neuro.	612	437	430	7			175	175				71.4	70.4
Radiology	382	312	297	15			70	70				81.6	81.1
Surg.	1080	839	809	30			241	240	1			77.6	79.1
Thor. Surg.	68	55	55				13	13				80.8	74.5
Urol.	277	161	156	5			116	116				58.1	57.9
Podiatry	382	361			361		21			21		94.5	95.3
General	2772	2525	1994	531			247	201	46			91.0	91.8
Total	11295	8859	7683	713	361	102	2436	2348	56	21	11	78.4	79.5

OFFICERS

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Joseph P. Donnelly, M.D., President

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W. John Gould, Vice-President—Corporate
Planning and Finance

Jerome C. Rothgesser, M.D.
Vice-President—Medical Affairs
and Medical Director

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Theron L. Marsh (1974)
John J. McGuire, M.D. (1976)
Walter H. Miller, D.O. (1973)
Henry J. Mineur, M.D. (1976)
William Mortenson (1975)
John R. Nevin (1976)
Zelda J. Paulsen (1974)
Ronald K. Sevwert (1976)
Irving E. Shaffer (1974)
Warren H. Simmons, Jr. (1975)
Sidney I. Simon, Ph.D. (1975)
Morgan Sweeney (1975)
Charles O. Tyler, M.D. (1974)
Robert E. Verdon, M.D. (1975)

TRUSTEES EMERITUS

	Appointed	*Term as Board Member*
Joseph I. Echikson, M.D.	1970	1954-1970
Elton W. Lance, M.D.	1971	1962-1971
*Edward W. Sprague, M.D.	1966	1942-1966
John S. Thompson	1966	1942-1965
Thomas J. White, M.D.	1973	1951-1973

ADVISORS TO THE BOARD OF TRUSTEES

	Appointed	*Term as Board Member*
William F. Costello, M.D.	1958	1948-1958
Andrew P. Dedick, M.D.	1973	1961-1973

CONSULTANT TO CHAIRMAN OF BOARD

	Appointed	*Term as Board Member*
Irving P. Borsher, M.D.	1965	1950-1965

*Deceased February 21, 1974

Filed (page Tr 142)

ACTION TO LIMIT DEBATE

At its first session on Saturday, May 11, 1974, the House of Delegates agreed, upon motion, that no one may speak more than once on any given subject, except by express permission of the House; and that the time be limited to four minutes per speaker, subject to the same exception.

New Jersey Foundation for Health Care Evaluation

Richard E. Lang, M.D., President, Passaic

(Reference Committee "B")

The creation of the New Jersey Foundation for Health Care Evaluation was adopted on December 10, 1972 at a meeting of the House of Delegates at a special session in Trenton. Emergency funds were allocated at that time for the formation of the Foundation until a budget could be developed and staff hired. At the May 1973 Annual Meeting of The Medical Society of New Jersey, funds were allocated for a one year period beginning June 1, 1973. A special assessment was levied on the membership of The Medical Society of New Jersey in the form of $10 to be added to their annual dues. On May 17, 1973 the House of Delegates of the New Jersey Association of Osteopathic Physicians and Surgeons unanimously voted financial support of the New Jersey Foundation for Health Care Evaluation.

During the months prior to June 1, 1973, MSNJ and NJAOPS began the planning process, developing organizationally and preparing a Constitution and By Laws which would legally incorporate the Foundation as a non-profit entity in the State of New Jersey. On April 1, a full-time administrator was hired.

April 18, 1973 the Foundation became a legal entity in the State of New Jersey with a charge to register iteslf as a public Foundation and obtain a non-profit status, 501 (c) 3, under Federal Statutes.

On June 1, 1973 a secretary was added to staff and funds became available from MSNJ and NJAOPS at the rate of $6,600 per month, to terminate May 31, 1974.

Purpose

In designing its goals for 1973-74, the Board of Trustees set forth in Article II of its Certificate of Incorporation the following objectives:

1. Promote, foster and develop the availability of quality health care, either alone or in conjunction with individuals, doctors, hospitals, schools, or corporations, organizations, foundations, funds, institutions or governmental bodies.

2. Encourage entry into the health care system of every person within this State.

3. Promote, develop and establish standards for quality health care based upon the professionally recognized practices of physicians licensed and practicing in the State of New Jersey.

4. Promote, organize and operate peer review activities that provide objectivity in dealing with health care costs, assist in determining medical necessity, and proper utilization of services encompassing the total health needs of patients according to established standards.

5. Promote, foster and coordinate the involvement of the health professions in development and evaluation of activities directed to relieving acute manpower shortages, improving the availability of preventive services and expanding the availability of appropriate ambulatory care as an alternative to institutional services and to provide information concerning these activities to individuals, doctors, hospitals, schools, foundations, institutions, governmental bodies, corporations and the general public.

6. Promote, develop and coordinate involvement by the health professions in comprehensive health care planning and area medical program activities.

7. Assist in the development and establishment of acceptable standards for comprehensive health insurance coverage.

8. Inform the general public of the aims and activities of this corporation in a manner intended to invite public involvement.

9. Effect any of these purposes either directly or by making or providing donations, gifts, grants, contributions, loans, guarantees, or use of the net income of the principal assets of the corporation.

10. Lessen burdens of government by the implementation of Public Law 92-603 as it relates to Professional Standards Review Organizations.

Accomplishments

In reviewing the achievements of one year's work, it is pointed out with great pride that practicing physicians of every county in the State of New Jersey donated their valuable time in addressing the issues without compensation of any kind. The physician time can only be estimated in terms of thousands of man hours with input of hundreds of physicians. To their dedication we stand indebted. To their achievement we offer:

1. Patterns of Care for Inpatient Services
Emanuel Abraham, M.D., Monmouth County, Chairman

Physician developed norms of care for 134 diagnoses involving 14 subspecialty categories. These guidelines were established through the cooperation of specialty societies in New Jersey who donated their expertise in their own area of practice. This Book of Norms has been made available to every hospital in New Jersey, to serve as an educational tool in developing their own hospital standards. This effort was one in which, for the first time in New Jersey, organized medicine offered in a document format indicators for quality which represents the profession in our own State.

2. Peer Review
Arthur Bernstein, M.D., Essex County, Chairman

The Foundation, through this committee, developed a systematized approach toward practicing physician management and evaluation of services rendered in 107 hospitals in New Jersey. This Program was undertaken in the form of a proposal to the State Medicaid Department, Department of Institutions and Agencies. As proposed, the New Jersey Utilization Management Program offered an approach of Prospective, Concurrent, and Retrospective Review to be conducted by Regional Councils of physicians in New Jersey. The emphasis of this program is to provide the necessary monies, staff, and decision-making to practicing physicians in determining quality of care at a reasonable cost to 525,000 eligible Medicaid recipients in the State of New Jersey. Such programs coordinated at state levels are presently being conducted by physicians in Maryland, Massachusetts, Illinois, and Colorado. The estimated savings to the State of New Jersey is $8,000,000 in the first year of implementation. New Jersey's program is unique in that the emphasis is to be on quality evaluations as opposed to cost control. This program as outlined to the State is, in fact, a prototype for PSRO, designed and developed by physicians.

3. Comprehensive Health Insurance Guidelines
George L. Benz, M.D., Essex County, Chairman

This effort is devoted to exploring coverages for insurance policies as written in New Jersey, with the purpose of defining inadequacies that exist and recommendations for upgrading. Discussions were held with insurance representatives and research was done into programs sponsored by physicians across the country (Georgia; Colorado; San Joaquin, California; Orange County, California; etc.) as well as meetings with physician groups, led to an investigation of legislation proposed for National Health Insurance.

It became evident that the Administration Bill, as well as the Burleson-McIntyre Bill, offered the public a level of benefits superior in nature to existing coverage today. From indications given, it becomes apparent that National Health Insurance legislation will become a reality in 1974, supplying those benefits. The committee's recommendation is to support legislation mandating catastrophic coverage such as the Long-Ribicoff Bill and a government—private industry initiative as it appears today.

4. Committee on Professional Fees and Relative Value Index
Charles I. Nadel, M.D., Essex County, Chairman

The committee has explored the feasibility of a fee review program on a statewide basis for the purpose of obtaining reasonable fees for physicians in New Jersey, through a review system identifying guidelines for cases to be submitted by insurance companies writing the group insurance plans in this State. The Twin Cities, Minnesota Plan, as well as the Hartford County Health Care Plan were examined as prototypes for New Jersey.

Meetings with Blue Shield and Prudential, fiscal intermediaries, were held to determine charging patterns, as well as current review mechanisms. Specialty groups were asked to submit relative value indices to the Foundation and to submit values for the most common procedures.

In its deliberations the committee observed that such a program as statewide fee review requires total Foundation time, and would require a disruption in fee structure as it exists now, and which is justifiable by area physicians and insurance carriers.

From nationwide studies conducted it is apparent that physicians' fees do not constitute the problem of rising costs of care; rather, institutional costs have been the main category of increased escalation. Having identified the area of concern the Board decided to comment this committee for its work and gear its resources toward problem solving in immediate, more pressing areas.

5. Medical Audit and Utilization Review
Emanuel Abraham, M.D., Monmouth County, Chairman

Under the auspices of Dr. Abraham a Medical Record Abstract Committee was formed to study systems currently used by New Jersey hospitals in measuring both Medical Audit and Utilization Review. The committee's task included the recommending and designing of a system which could best serve the interests of the practicing physicians, as well as ensuring each hospital its viable role in determining a system compatible to its own needs.

An overview of New Jersey's hospitals brought forth a chaotic picture of institutions ranging from no method to too highly effective programs for institutional review. The overwhelming majority of hospitals would not be equipped to meet the mandates established by both Professional Standards Review Organizations and the Joint Commission on Accreditation of Hospitals. With the cooperation of the New Jersey Hospital Association and the Commission on Professional Hospital Activities (CPHA), it was concluded that of the 45 PAS and 13 HUP hospitals their systems of retrospective review would be adequate to meet mandated needs. From the viewpoint of PSRO legislation, concurrent and retrospective review programs were missing in virtually all hospitals that had systems. Such a system the Foundation would embark on designing with emphasis on quality review. A further recommendation was that while PAS and HUP offer adequate retrospective review, the PAS system appears to offer more medical data in terms of physicians review information.

6. Professional Standards Review Organizations (PSROs)

The vast majority of the Foundation's time was spent on this subject due to its immediate circumstances. In its involvement with peer review, the Foundation has, for the last twelve months, investigated PSRO, its origin, its presence, and its future in the State of New Jersey. An emotional problem that affects all physicians, PSRO is nevertheless a piece of legislation that demanded immediate attention. It has been an issue that has consumed physicians' thinking throughout the country and has led the Foundation physicians to become experts in its future ramifications.

The search for answers has led us to all portions of the country, inevitably to Washington and back to

New Jersey, bearing in mind that a mandate had come to the Foundation from MSNJ and NJAOPS to contract with the Department of HEW to be the PSRO in New Jersey. Comments are in order:

a. The Law, P.L. 92-603, specifically Section 249F, creates the establishment of PSRO units and the option of physician organizations to control these entities.

b. HEW intends to give local units the responsibility of local peer review through contractual arrangements.

c. State organizations in larger states are to be given the role of coordinating bodies in contractual agreements with HEW.

d. The New Jersey Foundation for Health Care Evaluation has, in 1973-1974, been involved in over 95 meetings which included county medical societies, hospital staff meetings, M.D. and D.O., Blue Cross—Blue Shield, Health Insurance Council, New Jersey Hospital Association, New Jersey Hospital Research and Educational Trust, State government, HEW Region II, Department of Professional Standards Review, Washington, D.C., Rutgers Department of Continuing Education, Prudential Insurance Company, Massachusetts Medical Society, Maryland Insurance Company, Virginia Medical Society, Delaware Medical Society, Pennsylvania Medical Society, legislators from New Jersey, Senator Wallace Bennett, Utah, American Association of Foundations for Medical Care, American Medical Association, American Hospital Association, Orange County, California Medical Society, Pacific Mutual Insurance Company, Commission on Professional Hospital Activities, and many other groups, all involved in PSRO, its education, development, and planning. It is for this reason that the Foundation has been able to be among the most knowledgeable organizations in the United States on the subject of PSRO.

e. As a result of four regional meetings sponsored by the Foundation in July, New Jersey physicians were able to designate their own PSRO areas whereby arbitrary designations by HEW were eliminated. Hospital staffs were included in the decision making process.

f. Newsletters on Foundation activities, as well as special reports, were circulated to 107 hospitals in New Jersey, updating PSRO and Foundation activities. County societies' presidents, M.D. and D.O., were also reported to.

Conclusion

After careful evaluation and study by the Board and legal opinions rendered by Foundation and AMA counsel, it is apparent that repeal of the PSRO law is not forthcoming. One PSRO status for New Jersey is not favored by governmental officials and there is a general feeling by New Jersey physicians that local control of PSRO is desirable.

The DHEW, realizing the importance of experienced state medical organizations and the need for local assistance, has designated the creation of PSRO Support Centers in states containing more than five PSRO areas.

Having reviewed the concept of the PSRO Support Center, the Board feels that this overall activity offers organized medicine at the state level a very influential role in keeping PSRO under the control of physicians in New Jersey. Physicians desiring their own local review organizations would also benefit in having the State organization available to meet their own needs and to avoid centralized control inherent in any State program. It is imperative that the Foundation fulfill its commitment to New Jersey physicians desiring to undertake PSRO by assuring them that peer review and all its ramifications remains in the hands of the practicing physicians. The number of Support Centers to be developed by medicine will be limited and the absence of such in New Jersey could require government to contract with a non-physician organization or a state medical society from a neighboring state to provide services for New Jersey PSROs. A fuller description of a PSRO Support Center is contained in a following section.

Regional Medical Programs

The Foundation, in 1973-74, has been the recipient of a grant award of $15,000 for the development of patterns of care for inpatient services, as well as a grant of $50,500 for assisting PSROs in formulating a plan for the evaluation of inhouse review mechanisms as mandated by P.L. 92-603.

Associations

The New Jersey Foundation for Health Care Evaluation has been elected a member foundation of the American Association of Foundations for Medical Care, with voting privileges in their House of Delegates.

MSNJ Journal

In a further effort to inform physicians of Foundation activities, two articles by Richard E. Lang, M.D., President, have appeared, "PSRO—Foundation Speaks Out on Area Designation", in the November 1973 edition, and "Foundation Interim Report", in the May 1974 issue.

Newsletters

The Foundation "Bulletin" has been published on a quarterly basis and distributed to Foundation membership, hospitals and county societies. This Bulletin contains Foundation activities, as well as PSRO and New Jersey events.

Counsel

James J. Madden, Esq., of the law firm Field and Madden, Collingswood, has been retained as Foundation counsel.

Consortium

The Foundation has begun to develop a committee of advisors from Blue Cross, Blue Shield, Prudential Insurance Company, and the New Jersey Hospital Association, whose purpose is to mutually cooperate in exchanging information and exploring ideas that can mutually benefit the health delivery system in New Jersey.

New Jersey Utilization Program

Sponsored by the Hospital Research and Educational Trust of New Jersey of the New Jersey Hospital Association, the Foundation has recommended seven practicing physicians to the Board of Managers who conduct that program.

Lay Membership of Foundation Board

The Executive Committee is in the process of inviting lay members to the decision-making process of the Foundation. Invitations to participate have been extended to representatives from:

Medical-Surgical Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Nursing Home Association
New Jersey Health Insurance Council
Fiscal intermediary for Medicare
Fiscal intermediary for Medicaid
New Jersey Hospital Association
New Jersey Commissioner of Health

Candidates from the public at large are also under consideration with representatives from labor, management, and the consumer being reviewed.

General Membership

Due to anticipation of PSRO status, an overall recruitment campaign for membership has been delayed until guidelines from HEW are released regarding the Foundation's role. During the course of 1973-74 the Foundation has accepted membership and has on display at its central office a roster of members. Those funds accumulated from members are held in escrow, available for disbursement to members upon the direction of the Federal guidelines.

Trustees

Representatives from each county medical society and four members of the New Jersey Association of Osteopathic Physicians and Surgeons represent the makeup of the Board of Trustees. Each Trustee is availed of minutes of the monthly meetings, including committee reports and pertinent materials.

Administration

A full-time Administrative Director and secretary constitute the staff of the Foundation. The principal office of business is at the Executive Offices of The Medical Society of New Jersey, 315 West State Street, Trenton. Office space has been donated by MSNJ; all other expenses are borne by the Foundation.

Financial Report

A balance sheet of the financial activities from June 1, 1973 to March 1, 1974 has been submitted to Reference Committee "B" of the House of Delegates for their information and perusal. Based on expenditures for this period, monies projected for the 12 month operational period will not exceed the year's budget allocations. Financial statements are available at the Foundation offices, 315 West State Street, Trenton.

Addendum

The work of the Foundation has not only been substantial but significant. The year 1973-74 has been one of development, growth, and potential. The fruits of labor have begun to show rewards.

Committee Structure

Executive Committee:

Richard E. Lang, M.D., President
Emanuel Abraham, M.D., First Vice-President
Sidney M. Grobman, D.O., Second Vice-President
Charles I. Nadel, M.D., Secretary
James A. Rogers, M.D., Treasurer
William J. D'Elia, M.D., President-Elect

Peer Review Committee on Professional Fees and Relative Value Index:

George L. Benz, M.D., Chairman
Donald P. Burt, M.D.
Leonard H. Grodsky, M.D.
Frederick J. Knocke, M.D.

Peer Review Committee on Standards of Care and Utilization:

Emanuel Abraham, M.D., Chairman
David R. Brewer, Jr., M.D.
Thomas J. Dougherty, M.D.
Milton Metzman, D.O.

Committee on Finance and Budget:

Charles L. Cunniff, M.D., Chairman
Sidney M. Grobman, D.O.
Charles S. Krueger, M.D.
Charles I. Nadel, M.D.
Lawrence B. Owen, M.D.
James A. Rogers, M.D.

Medical Record Abstract Committee:

Emanuel Abraham, M.D., Chairman
David R. Brewer, Jr., M.D.
Thomas J. Dougherty, M.D.
Emanuel Klosk, M.D.
Frederick J. Knocke, M.D.
Richard E. Lang, M.D.
Ralph J. Lewis, M.D.
Warren B. Nestler, M.D.
Daniel J. O'Regan, M.D.

Medicaid Proposal Committee:

Arthur Bernstein, M.D., Chairman
Frank L. Barham, M.D.
Charles S. Krueger, M.D.
Richard E. Lang, M.D.
Robert J. McNulty, D.O.
Warren B. Nestler, M.D.
Lawrence B. Owen, M.D.
James A. Rogers, M.D.
Charles E. Dooley, Jr., M.D., Consultant
Lorence Nagle, Consultant

PSRO Support Center Committee:

Frank L. Barhma, M.D.
Charles L. Cunniff, M.D.
Charles E. Dooley, Jr., M.D.
Floyd Krengel, D.O.
Richard E. Lang, M.D.
Daniel J. O'Regan, M.D.
Lawrence B. Owen, M.D.
James A. Rodgers, M.D.
Howard Zeidman, M.D.

Goals 1974-75

With the advent of Professional Standards Review Organizations, which is scheduled to begin on or before January 1, 1976, the Foundation will devote a great effort in securing organized medicine a role in the implementation of the eight designated areas, as well as a centralized agency for physician control of the Federal Program in New Jersey.

Statewide PSRO Support Center Contracts

In the December 20, 1973 Federal Register, proposed PSRO Area Designations were announced for the entire country. In the "Notice of Proposed Rule-Making," the Department indicated arrangements were being developed for existing organizations to provide assistance in a variety of administrative, organizational and professional matters to newly-formed Professional Standards Review Organizations. Statewide PSRO Support Centers will be established through competitive contracting to accomplish this purpose.

Purpose of Statewide PSRO Support Centers

The general purpose of Support Centers shall be to stimulate and support the development and operation of the PSRO program and the local PSRO's in a manner consistent with the legislative intent and the policies of the Secretary. Support Centers could thus provide professional, administrative and technical support to assist local PSRO's in carrying out their standard setting and peer review responsibilities. DHEW contracts with Support Centers would be let on a competitive basis and the tasks to be performed under all contracts and subcontracts would be subject to HEW approval.

Statewide PSRO Support Centers under DHEW Contract

The Support Centers' initial task would be to provide, as necessary, encouragement to physi-

cians in the local PSRO areas in organizing for the purpose of applying for designation as a conditional PSRO. The DHEW contract would call for the Support Center to:

1. Educate physicians about the PSRO program, peer review and quality assurance.

2. Identify physician groups who desire assistance in meeting the organizational and membership requirements of a PSRO.

3. Assist the physicians in the PSRO areas in meeting the organizational and membership requirements of a PSRO, including but not limited to:

(a) Developing an organizational format and structure as a nonprofit corporation consistent with DHEW rules, regulations, and guidelines.

(b) Developing bylaws that conform to guidelines set forth in the PSRO manual.

(c) Organizing programs to recruit broad physician membership on a continuing basis.

Also, upon request of a candidate PSRO, the Support Center may provide to such an emergent organization technical and professional assistance in the development of a formal plan, such as:

1. Assistance in the developing of review procedures, including methods for selection and rotation of reviewing health care professionals.

2. Assistance in familiarizing the PSRO with the options for peer review techniques based on PSRO manual guidelines.

3. Assistance in planning for the application of medical criteria and standards to the review of institutional care in short-stay hospitals and/or in long-term care institutions.

4. Assistance in the identification of specialists for recruitment as reviewers.

5. Assistance in formulating a plan for the evaluation of in-house review mechanisms.

Role of Support Centers in Conditional and Operational PSROs

Support Centers may also provide needed forms of technical and professional assistance to conditional and operational PSROs upon their request, such as:

1. Assistance in the further development and elaboration of review procedures.

2. Assistance in the continuing recruitment of all types of physicians to ensure a broad base of physician reviewers.

3. Assistance in developing procedures for development of special criteria necessary for the conduct of medical care evaluation studies.

4. Assistance with the analysis and use of data to support PSRO review activities.

5. Assistance in planning programs to train physicians to perform review activities, to conduct medical care evaluation studies, and to interpret aggregate data related to review.

6. Assistance in developing output formats to measure objectively the effectiveness of review efforts of individual institutions and of the PSRO.

7. Provide common professional and technical services to PSROs as appropriate.

8. Assist the Secretary and PSRO State Councils in coordination and evaluation of PSROs.

Role of Support Centers in Assisting State PSRO Council

Support Centers may enter into contracts with a State PSRO Council at the latter's request. Under such agreements the Support Center may:

1. Assist in the dissemination of information among PSROs.

2. Assist in ensuring sufficient expertise for specialty review in all PSROs within the State.

3. Assist in coordinating the data requirements of PSROs in line with the responsibilities of the State Council.

4. Assist in fostering cooperation between PSROs and appropriate health planning bodies.

5. Assist in developing relationships between individual PSROs and Statewide health and health-related agencies.

Statewide PSRO Support Centers' Fundamental Qualifications

To qualify as a Support Center an organization must:

1. Be composed primarily of physicians practicing within the State which the organization proposes to serve and have continuing relationships with State medical and other health professional societies, agencies and organizations.

2. Demonstrate that the physicians in the State desire technical assistance from the applicant organization.

3. Demonstrate knowledge of and expertise in the conduct of PSRO-like peer review activities.

4. Demonstrate experience and competence in other areas in which they propose to furnish services.

5. Demonstrate that the workload proposed by the Support Center will be sufficient to require a direct contract with DHEW, particularly in terms of the number of PSROs served.

PSRO—Private Sector Involvement

1973-74 has paved the way for initial discussions with representatives of third parties in anticipation of PSRO activities across the board to all patients in the State of New Jersey. The Foundation will offer its services in initial conversations with the private sector and identify the roles to be played in the future.

Nursing Home Review Programs

A definite need has been portrayed in this area of activity with an opportunity for practicing physicians to begin to explore the following of acute care patients into extended care facilities, and the establishment of criteria for evaluating and monitoring the quality of care being rendered in those institutions.

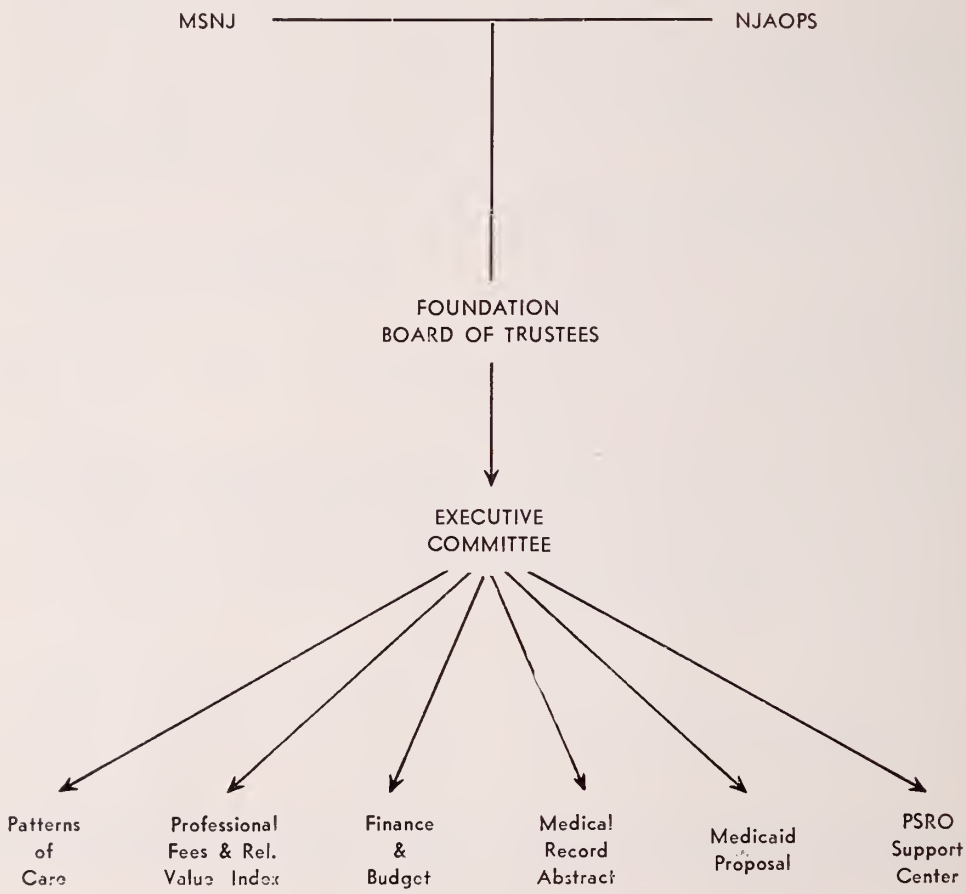
Health Maintenance Organizations (HMO's)

These alternate modes of delivery of health care services have begun to develop in New Jersey, and due to Federal monies (HMO Act of 1973) becoming available, make 1974-75 a year that organized medicine takes a lead in studying new developments, establishing expertise in this area, and formulating methods of evaluating the effectiveness and efficacy of these organizations in New Jersey.

The Foundation would seek Federal monies to act as a clearinghouse of information as well as an instrument for physician groups seeking involvement in HMO activities in their areas.

Educational Seminars

Due to the rapid anticipation of change to



take place, the Foundation intends to keep the medical profession abreast by sponsoring educational programs on issues of major concern, such as peer review, PSRO, and HMO. Efforts will be made by the Foundation to have these sessions approved for continuing medical educational requirements as established by The Medical Society of New Jersey.

Provider Relations

The Foundation Board membership will soon be completed, which is a beginning of physician-nonphysician relationships, and will offer a dialogue with key leaders in the State.

Expansion

In order to meet the needs for 1974-75, anticipated Federal monies will be used for hiring additional staff, as well as acquiring space outside the Executive Offices of The Medical Society of New Jersey in Trenton. Full details cannot be anticipated at this time due to the variables involved in the planning and funding process.

Funding

The Foundation is planning to conduct itself in non-PSRO activities as well as PSRO activities in the coming year. It is essential that the Foundation does not become a Federal mechanism and remains a vehicle of physician direction and control. As such, monies to support Foundation growth and development should come from non-governmental sources, such as the private sector and the physician community. This will be a priority for the Board of Trustees in 1974-75.

Constitution and Bylaws

In order to meet changes in policy the original ByLaws and Constitution may be subject to amendment, depending upon full Board composition.

Filed (page Tr 141)

Supplemental Report

Report of Treasurer

James A. Rogers, M.D., Paterson
(Reference Committee "B")

This 1974 interim financial report of your Treasurer has been prepared from the books and records of the New Jersey Foundation for Health Care Evaluation.

The Balance Sheet is presented as of March 31, 1974. These figures have not been audited, for the reason that the fiscal year of the Foundation does not end until May 31, 1974.

The Statement of Revenue, Expenditures, and General Surplus Unappropriated present the transactions of the Foundation for the ten months ended March 31, 1974.

Revenues have been examined on a test basis and disbursements have been test checked to supporting vouchers by the Foundation's independent accountants. The cash balance at March 31, 1974 was reconciled with the bank statement but was not confirmed direct with the depository. Revenues from grants to the Foundation were checked to the supporting details on file, but were not independently confirmed at this time.

These financial statements have been prepared in conformity with Resolution #28 approved by the 1968 House of Delegates of The Medical Society of New Jersey under the heading "Annual Financial Report."

Balance Sheet—March 31, 1974
(Unaudited)
Assets

Cash—Treasurer's General Checking	$10,467.09
Office Petty Cash Fund	500.00
Due from The Medical Society of New Jersey	3,850.00
	$14,817.09

Liabilities and Fund Balance

Liabilities:	
Unexpended Budget Appropriations	$15,752.48
Accounts Payable	262.78
Payroll Taxes Payable	1,641.83
Fund Balance—Unappropriated (Deficit)	(2,840.00)
	$14,817.09

Statement of Revenue, Expenditures and Fund Balance (Unappropriated) for the Ten Months Ended March 31, 1974 (Unaudited)

Revenue:	
Medical Society of New Jersey Grant	$63,850.00
New Jersey Association of Osteopathic Physicians and Surgeons	6,600.00
Membership Application Fees	820.00
General Contributions	50.00
Total Revenue	$71,320.00
Expenditures—Budget Appropriations (12 months)	$74,160.00
Excess of Expenditures over Revenue	(2,840.00)
Fund Balance (Unappropriated):	
Balance, Beginning	—0—
Balance, Ending (Deficit)	$ (2,840.00)

Statement of Expenditures for the Ten Months Ended March 31, 1974 (Unaudited)

Account	Adopted Budget	Total Expended	Balance Unexpended
Administrative			
Director's Salary	$17,000.00	$14,166.60	$ 2,833.40
Secretary's Salary	9,000.00	6,791.78	2,208.22
Salary Taxes	1,100.00	1,991.50	(891.50)
Employee Benefits, Health Insurance, Life Insurance and Pension	960.00	328.41	631.59
Additional Clerical Services	—	96.15	(96.15)
Book of Norms	20,000.00	—	20,000.00
Supplies and Stationery	2,000.00	2,555.81	(555.81)
Postage	2,500.00	882.02	1,617.98
Telephone	1,500.00	520.69	979.31
Legal	5,000.00	1,467.46	3,532.54
Accounting	2,100.00	165.00	1,935.00
Consultant Fees	—	25,499.57	(25,499.57)
Insurance	—	353.00	(353.00)
Conferences and Travel:			
President, Administrative Director and Other	4,000.00	1,409.24	2,590.76
Mileage and Parking	1,500.00	711.80	788.20
Provider Relations —Meeting and Conferences	7,500.00	1,468.49	6,031.51
Total Budget Appropriations	$74,160.00	$58,407.52	$15,752.48

Filed (page Tr 141)

Reception Honoring President-Elect Rogers

President Boylan — President-Elect Rogers

1st Vice-President McGuire — Immediate Past-President D'Elia

Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1974 Annual Meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

Atlantic County

Clarence B. Whims, M.D., Ventnor City; Age 69.

Bergen County

Roslyn Barbash, M.D., Teaneck; Age 62
Frank F. Becker, M.D., Ridgewood; Age 65
Armin W. Docter, M.D., New York, N.Y.; Age 61
William J. Greenfield, M.D., Palm Beach, Fla; (formerly Hackensack) ; Age 84
Russell F. Maddren, M.D., San Mateo, Cal. (formerly Hackensack) Age 86
George O. Rowohlt, M.D., Dumont; Age 68
Louis M. Sosnow, M.D., Hillsdale; Age 69

Burlington County

E. Vernon Davis, M.D., Kitty Hawk, N.C. (formerly Moorestown) ; Age 68

Essex County

Milton W. Amster, M.D., Ft. Lauderdale, Fla. (formerly So. Orange) ; Age 65
C. Abbott Beling, M.D., Blairstown (formerly Montclair) ; Age 68
Charles J. Calasibetta, M.D., Williamsport, Pa. (formerly Newark) ; Age 67
John J. Connolly, M.D., Spring Lake (formerly Newark) ; Age 75
Robert F. Dow, M.D., Cape Coral, Fla. (formerly Montclair) ; Age 65
Hyman Friedman, M.D., Pembroke Pines, Fla. (formerly E. Orange) ; Age 74
Charles R. Harms, M.D., Mantoloking (formerly U. Montclair) ; Age 59
Joseph Levin, M.D., Millburn; Age 73
James H. MacArt, M.D., Nokomis, Fla. (formerly Millville) ; Age 63
Richard E. Mauer, M.D., Rutherford; Age 58
Clarence W. Moeckel, M.D., Upper Montclair; Age 69
Edward D. Reifenstein, Jr., M.D., Butler; Age 65
David C. Roberts, M.D., New Orleans, La. (formerly Summit) ; Age 69
Jacob W. Siegel, M.D., Madison; Age 82
Arthur C. Thornhill, M.D., Montclair; Age 78
Kurt W. Thum, M.D., Whiting (formerly W. Orange) ; Age 72
Asher Yaguda, M.D., Port Jervis, N.Y. (formerly Newark) ; Age 77
John L. Work, M.D., Upper Montclair; Age

Mercer County

Sidney B. Lavine, M.D., Yardley, Pa. (formerly Trenton) ; Age 69
Gerald H. Miller, M.D., Cranbury; Age 71
Morton L. Poyas, M.D., Trenton; Age 70
Edward L. Waldron, M.D., Trenton; Age 70

Middlesex County

Stanley J. Gobel, M.D., Bound Brook; Age 69
Irving M. Silber, M.D., East Brunswick; Age 60
William Stein, M.D., New Brunswick; Age 67
James S. Winn, M.D., Bound Brook; Age 67

Morris County

Daniel G. Melvin, M.D., Lakewood (formerly Greystone Park) ; Age 69
Harold J. Muendel, M.D., Basking Ridge; Age 66
Merlin T. Ryman, M.D., Chatham; Age 66
Charles C. Scott, M.D., Morris Plains; Age 65

Ocean County

Thomas J. Green, M.D., New Egypt; Age 65

Passaic County

J. Vernon Hughes, M.D., Clifton; Age 77
Paul Rauschenbach, M.D., Paterson; Age 65
Jacob Stark, M.D., Paterson; Age 70

Salem County

Claude B. Mackes, M.D., Woodstown; Age 70

Somerset County

Anthony J. Allegrante, M.D., Branchville (formerly Somerville) ; Age 67

Union County

Harry Arons, M.D., Rossmoor (formerly Elizabeth) ; Age 67
Delma W. Caldwell, M.D., Westfield; Age 63
Neil Castaldo, M.D., Cranford; Age 66
Ferdinand J. DeCesare, M.D., Lakewood (formerly Roselle Park) ; Age 74
Clarence T. Hill, M.D., Miami, Fla. (formerly Rahway) ; Age 72
Frederick Hnat, M.D., Mantoloking (formerly Elizabeth) ; Age 72
Adele C. Shepard, M.D., Elizabeth; Age 60
E. Milton Staub, M.D., Westfield; Age 68

Filed (page Tr 151)

Supplemental Report

Camden County

Joseph M. Stein, M.D., Cherry Hill; Age 71

Hudson County

G. Thomas DeFusco, M.D., Deal; Age 67
Benjamin Jaffe, M.D., Jersey City; Age 70
Charles A. Landshof, M.D., Jamesburg; Age 69
Robert B. Lobban, M.D., Jersey City; Age 70
Frank W. Mahoney, M.D., Weehawken; Age 66

Filed (page Tr 151)

President-Elect and Mrs. Rogers and Family

MEMORIAL RESOLUTIONS

The following resolutions were received by the House with sorrowful concurrence

Robert Clifford Anderson, M.D.
(1908-1974)

Whereas, Almighty God has summoned from our midst his good servant and our beloved colleague, Robert Clifford Anderson, M.D.; and

Whereas, as a member of the Board of Trustees of The Medical Society of New Jersey, Doctor Anderson rendered uniformly high and valuable service to The Medical Society of New Jersey and the people of our State; and

Whereas, by his industry, understanding, dependability, and kindness he won the affectionate esteem of all who knew him; now therefore be it

RESOLVED, that The Medical Society of New Jersey, honoring Robert Clifford Anderson, M.D., in death as in life, records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting and that another copy, suitably prepared, be presented to his bereaved family in token of heartfelt sympathy.

Henry A. Davidson, M.D.
(1905-1973)

Whereas, Almighty God, the supreme author of life and action, in his unchallengeable wisdom, has written "finis" to the vigorous life history of Henry A. Davidson, M.D.; and

Whereas, through a generation of service, Doctor Davidson has won national renown as the illustrious Editor of *The Journal* of The Medical Society of New Jersey; and

Whereas, by his literary genius, his kindly wit, and his profound expansive professional knowledge, he has consistently reflected credit upon The Medical Society of New Jersey; now therefore be it

RESOLVED, that The Medical Society of New Jersey records its lasting indebtedness to Henry A. Davidson, M.D., Editor extraordinaire, literary and scientific authority par excellence, distinguished physician and delightful and amiable associate, whom others may succeed but no one can replace; and be it further

RESOLVED, that it records its heartfelt grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting and that another copy, suitably prepared, be presented to his bereaved widow and family in token of heartfelt sympathy.

RESOLUTIONS

#1

Apportionment of MSNJ's House of Delegates

From the Ocean County Medical Society

(Reference Committee "A")

Whereas, the total number of physician members of The Medical Society of New Jersey is presently increasing; and

Whereas, the House of Delegates has been fixed at a maximum of 400, necessitating a numerical ratio varying from year to year; and

Whereas, this ratio may further constrict the number of delegates from smaller counties, in turn decreasing their voices and representation; and

Whereas, the Constitution and Bylaws indicated a minimum of only three delegates; now therefore be it

RESOLVED, that no county shall have less than six delegates as a minimum and that the Constitution and Bylaws be amended to reflect this change.

Rejected (page Tr 139)

#2

Consultation with MSNJ's Councils and Committees

From the Passaic County Medical Society

(Reference Committee "A")

Whereas, the Board of Trustees of The Medical Society of New Jersey has supported a proposal that a School of Professional Psychology be located in the College of Medicine and Dentistry of New Jersey; and

Whereas, this was done without consulting the Council on Mental Health of The Medical Society of New Jersey or the concerned specialty group; now therefore be it

RESOLVED, that the House of Delegates sternly affirm that the Board of Trustees of The Medical Society of New Jersey must consult, in a meaningful fashion, its own councils relating to the various aspects of medical practice in the state, and, in addition, consult those recognized organizations representing bonafide groups of physicians such as the New Jersey Psychiatric Association or the American Academy of Family Physicians, etc., when the interests of such physicians come before the Board of Trustees.

Adopted with notation (page Tr 139)

#3

MSNJ Support of Federal Gun Control Legislation

From the Passaic County Medical Society

(Reference Committee "A")

Whereas, because of the lack of federal gun control legislation, illegal firearms are entering New Jersey in spite of an adequate state gun control law; now therefore be it

RESOLVED, that The Medical Society of New Jersey go on record in favor of federal gun control legislation.

Adopted (page Tr 139)

#4

Use of the Physician Taxpayer Identification Number

From the Union County Medical Society

(Reference Committee "A")

Whereas, the New Jersey Division of Consumer Affairs, in the July 1973 re-registration of physicians, requested the taxpayer identification number (social security number) of each physician; and

Whereas, The Medical Society of New Jersey, in its December 1973 "Verification of Data" of Society members, requested the taxpayer identification number (social security number) of each member; and

Whereas, the July 1973 Report of the United States Secretary of Health, Education, and Welfare Advisory Committee on Automated Personal Data Systems recommended "specific, pre-emptive, federal legislation" providing:

That an individual has the right to refuse to disclose his Social Security Number (taxpayer identification number) "to any person or organization that does not have specific authority provided by federal statute to request it";

now therefore be it

RESOLVED, that The Medical Society of New Jersey not request or use the taxpayer identification number (social security number) of any member for any purpose; and be it further

RESOLVED, that The Medical Society of New Jersey be recorded as being opposed to the request for, or the use of, the taxpayer identification number (social security number) of any persons by the Division of Consumer Affairs of the Department of Law and Public Safety of New Jersey for licensure or licensure registration purposes, or by the State Board of Medical Examiners of New Jersey for licensure or registration purposes for physicians; and be it further

RESOLVED, that copies of this resolution be sent to the Secretary of the State Board of Medical Examiners of New Jersey, the Director of the Division of Consumer Affairs, Department of Law and Public Safety of New Jersey, and the New Jersey Commissioner of Health.

Adopted (page Tr 139)

#5

Funding of the New Jersey Foundation for Health Care Evaluation

From the Union County Medical Society

(Reference Committee "B")

Whereas, the United States Department of Health, Education, and Welfare has designated PSRO districts for New Jersey; and

Whereas, there will be no statewide PSRO for New Jersey; and

Whereas, the New Jersey Foundation for Health Care Evaluation was established by The Medical Society of New Jersey "for recognition as the PSRO for the State of New Jersey"; and

Whereas, the New Jersey Foundation for Health Care Evaluation has not been so recognized; and

Whereas, any advisory or educational functions of the New Jersey Foundation for Health Care Evaluation would be equally well provided by appropriate committees or councils of The Medical Society of New Jersey; now therefore be it

RESOLVED, that The Medical Society of New Jersey provide no further funds to the New Jersey Foundation for Health Care Evaluation.

Rejected in conformity with House approval of special $10 assessment to serve as a grant to the New Jersey Foundation for Health Care Evaluation—recommendation #3 in the Finance and Budget Committee report (page Tr 141)

#6

Amendment of PSRO and Evaluation of the New Jersey Foundation for Health Care Evaluation

From the Ocean County Medical Society

(Reference Committee "B")

Whereas, on May 9, 1972, the House of Delegates of The Medical Society of New Jersey, in response to Resolution #26, resolved to convene a special meeting on December 10, 1972; and

Whereas, the House of Delegates on December 10, 1972, resolved to proceed with all deliberate speed to establish a separate entity named "The New Jersey Foundation for Health Care Evaluation"; and

Whereas, the presumption and understanding was that this single Foundation would serve as a single PSRO for the normal geographical State of New Jersey; and

Whereas, the request for a single PSRO as represented by the aforementioned Foundation was communicated to the United States

Department of Health, Education, and Welfare at a meeting in July, 1973; and

Whereas, with total disregard to the foregoing planning and requests, the Department of Health, Education, and Welfare divided New Jersey into eight PSRO areas; now therefore be it

RESOLVED, that The Medical Society of New Jersey re-examine and re-evaluate the function of the New Jersey Foundation for Health Care Evaluation as related to its wishes and the authority granted it; and be it further

Adopted, in conformity with prior action of the House (page Tr 141)

RESOLVED, that The Medical Society of New Jersey cease to cooperate with the Department of Health, Education, and Welfare on any matters related to PSRO; and be it further

Rejected (page Tr 141)

RESOLVED, that The Medical Society of New Jersey actively seek by whatever means possible to have the PSRO repealed.

Foregoing "resolved" amended to read:

RESOLVED that The Medical Society of New Jersey actively seek to have the PSRO law amended.

Adapted as amended by House (page Tr 141)

#7

Action of Blue Shield of New Jersey in Reference to Other Plans Employing "Hold-Harmless" Clause

From the Union County Medical Society

(Reference Committee "C")

Whereas, some Blue Shield Plans write contracts which contain the "hold-harmless" clause; and

Whereas, this enables such plans to render legal aid to individuals covered under such contracts when there are legitimate differences regarding fees; and

Whereas, such a procedure violates the freedom of the private practice of medicine and interferes with normal physician-patient relationships; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey urge and petition Blue Shield of New Jersey not to participate or cooperate with any Blue Shield Plan or insurance company which contains the "hold-harmless" clause and the proposal to render legal aid to holders of such contracts.

Rejected (page Tr 142)

#8

Exclusion of First Fourteen Days of Life in Health Insurance Policies

From the Essex County Medical Society

(Reference Committee "C")

Whereas, it is recognized that the nation's most valuable resource is its children; and

Whereas, it is recommended that every infant receive quality medical supervision in the earliest period of life; and

Whereas, the private insurance industry offers exclusion from coverage for the first fourteen days of life in many policies; and

Whereas, coverage of the newborn is presently available under Blue Cross and Blue Shield in New Jersey, indicating its feasibility; and

Whereas, certain health problems in children are readily identified and best treated in the first days of life, and, consequently, this exclusion is not for the benefit of child health or the family's well-being; now therefore be it

RESOLVED, that The Medical Society of New Jersey vigorously support the eradication of the fourteen-day clauses from health insurance policies sold in the State of New Jersey as being discriminatory to the newborn infant.

Adopted (page Tr 143)

#9

Federal Catastrophic Health Insurance

From the Essex County Medical Society

(Reference Committee "C")

Whereas, mail received by legislators does not indicate a major health-care crisis, but does reflect a growing concern that a long-term illness could deplete a family's savings or retirement funds; and

Whereas, the AMA has recognized in its Medicredit Program that "advances in science and in medical and health-care techniques, along with inflation throughout our economy, have driven up the cost of care to the point that even a person of moderate to good income can be left economically drained or seriously in debt after a long or severe illness"; and

Whereas, a well-planned catastrophic coverage would not obligate the nation's taxpayers to pay for care of people who can afford to handle most of their medical problems themselves; and

Whereas, expensive, long-term kidney disease has already been covered by federal legislation initiated from outside the profession, and other piecemeal plans are proposed and inevitable; now therefore be it

RESOLVED, that The Medical Society of New Jersey request the American Medical As-

sociation, through resolution at the June 1974 AMA Convention, to assume the leadership in this field; and be it further

RESOLVED, that the AMA draft, and actively seek, implementation of a catastrophic health-care plan as a separate legislative entity which would provide federal assistance to those with unduly burdensome health-care financial problems; and be it further

RESOLVED, that, if across-the-board catastrophic coverage is introduced from other sources and is one that can be lived with by the private sector, the AMA lend this legislation its unequivocal and vocal support.

Adopted (page Tr 143)

#10

Handling of Malpractice Suits

From the Union County Medical Society

(Reference Committee "C")

Whereas, the practicing physicians of New Jersey are increasingly confronted with lawsuits for reasons of real or alleged malpractice; and

Whereas, the system of voluntary mediation adopted by the Supreme Courts of New Jersey in February of 1966 has steadily declined in effectiveness since its inception to a point now where it is scarcely being utilized at all; and

Whereas, New York County has apparently benefited from the adoption of an initial compulsory mediation* program promulgated by the Supreme Court of the State of New York; and

Whereas, a current analysis of actual cases mediated there attests to the fact that out of a total of 230 cases (1971-72) thirty per cent were resolved without further judicial action; and

Whereas, it is the opinion of the joint interprofessional committee in New York that with some improvements in procedure the current rate of thirty per cent could be bettered; now therefore be it

RESOLVED, that The Medical Society of New Jersey recommend to the Supreme Court of New Jersey that all malpractice cases be first presented to a special mediation panel; and that the panel be composed of three persons—a judge, a physician, who is expert in the specialty of medicine involved in the case, and an attorney whose expertise lies in the area of litigation.

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*Please note that this calls for mediation and not arbitration.

Rejected with notation (page Tr 143)

#11

Payment by Blue Shield for Medical Consultation in Consultant's Office

From the Union County Medical Society

(Referenee Committee "C")

Whereas, surgical cases being processed through hospital pre-admission testing programs not infrequently bring to light medical problems which necessitate medical consultation prior to surgery; and

Whereas, it is often impossible to secure such consultation on an inpatient basis in the limited time available between admission and the time of scheduled surgery; and

Whereas, such consultation could more easily be secured in the office of a medical consultant; and

Whereas, the present situation may and does result in the cancelling of surgical operations and the rescheduling of the same, with the loss of valuable time in the hospital at considerable cost to the Blue Cross Plan; now therefore be it

RESOLVED, that the House of Delegates recommend that the Medical-Surgical Plan of New Jersey (Blue Shield) include fees for such consultations in its benefits.

Referred to Council on Medical Services upon recommendation of Reference Committee (page Tr 143)

#12

Rehabilitation Coverage

From the Essex and Passaic County Medical Societies

(Reference Committee "C")

Whereas, physical medicine and rehabilitation is a board certified, recognized medical specialty; and

Whereas, it is recognized that disability may be minimized and ability maximized through early rehabilitation medicine services; and

Whereas, disabled patients deserve access to quality rehabilitation care at the most optimum period of their disability and illness; and

Whereas, the Medical-Surgical Plan of New Jersey and other third parties limit the coverage to patients of rehabilitation services to the extent that optimal improvement is impaired; and

Whereas, certain recognized diagnostic procedures performed by the specialists in physical medicine and rehabilitation are not reimbursed by some third parties; and

Whereas, the coverage of rehabilitation days

both for those in hospitals and in extended care facilities is curtailed by administrative decisions instead of by policy right; and

Whereas, ambulatory rehabilitation care is not adequately covered under existing policies for the benefit of the patient; now therefore be it

RESOLVED, that The Medical Society of New Jersey vigorously support the extension of physical medicine and rehabilitation health insurance to adequately cover the patient disabled by illness and trauma; and be it further

RESOLVED, that The Medical Society of New Jersey petition the Medical-Surgical Plan of New Jersey to adopt rehabilitative coverage on a hospital inpatient and outpatient basis, and follow-up care at a skilled nursing facility comparable to Medicare coverage; and be it further

RESOLVED, that the electrodiagnostic services (e.g. electromyography and nerve conduction studies) be included as reimbursable medical services.

Referred to Council on Medical Services upon recommendation of Reference Committee (page Tr 143)

#13

The Reform of Medical Malpractice Law

From the Union County Medical Society

(Reference Committee "C")

Whereas, the present medical malpractice law promotes economic hardship on patient and physician alike; and

Whereas, a compensation system, embodying salient features of the no-fault, arbitration and workmen's compensation systems would promote faster and fairer settlements of malpractice cases; and

Whereas, medical-legal boards allowing for the full protection of the rights of both patient and physician would eliminate awards based on emotion rather than scientific analysis; now therefore be it

RESOLVED, that the House of Delegates study and propose to the legislature of the State of New Jersey a series of changes to create a practical, realistic, and equitable medical malpractice law in the State of New Jersey as per addendum.

There is a medical malpractice crisis and the state legislature should be urged to help in medical malpractice reform without delay.

The institution of a protective mantle for physicians is considered neither realistic nor desirable by practicing physicians who realize that such a step could lead to flagrant abuse.

The following measures might add up to a more realistic legislative approach:

a. Medical boards must have immunity of law in the realm of license suspension and the scope of the board must extend beyond criminal offense.

b. State medical discipline committees must be established, with control over all physicians in the state, licensed or unlicensed, members of medical societies or not.

c. Statewide medical foundation to do peer and utilization review.

d. An absolute statute of limitations for actuarial purposes, possibly with the only exception being an extension to provide the patient necessary medical expenses without other remuneration.

e. It would seem reasonable for the plaintiff to carry the burden of proof and possibly post a bond that would be non-returnable if the case was either lost

or dismissed (such a bond could help defray defense costs as well as be a necessary deterrent.)

f. Appropriate discovery methods for obtaining and analyzing medical records both in the office and hospital are of extreme importance for the proper evaluation of suit potential.

g. Some type of control of contingency fee system, possibly on a sliding scale basis, would appear to be necessary in that more realistic percentages could be more reasonably approached.

h. The establishment of a system similar to the Workmen's Compensation Board, either with or without a pain and suffering component, be carefully scrutinized by the legislative body. The uniformity of such a system would make actuarial analysis more realistic and ultimate premiums more workable.

i. With the present tendency toward higher and higher awards, it would seem that ceilings on settlements are a necessity, the only exception being gross negligence where a punitive factor could be superimposed.

j. The replacement of emotionally charged juries with panels of medical-legal experts would eliminate the guesswork and institute a more scientific analytic approach to the problem.

Referred to Council on Legislation upon recommendation of Reference Committee (page Tr 143)

Executive Assistant Martin Johnson and members of MSNJ staff

#14

Amendment of the Lien Law Pertaining to Physicians

From the Union County Medical Society

(Reference Committee "E")

Whereas, inasmuch as the lien law of the State of New Jersey is based on the existence of negligence; and

Whereas, inasmuch as the no-fault automotive law of the State of New Jersey in its present form renders the lien process inoperative except in instances wherein action for negligence is pending; now therefore be it

RESOLVED, that the law of liens pertaining to physicians be amended to permit the existence of a lien on proceeds due the insured patient under the provisions of the personal liability section of his automotive insurance policy, this being for legitimate services rendered to the insured by the treating physician.

Adopted (page Tr 145)

#15

Laboratory Service Billing Act

From the Ocean County Medical Society

(Reference Committee "E")

Whereas, the disclosure of the physician's cost of laboratory tests to his patients may not accomplish the stated purpose of Assembly Bill 2317 (recently signed into law); and

Whereas, physicians may elect to perform all tests in their own offices or refer patients to local laboratories or hospital laboratories; and

Whereas, surveys of such lab work reveal that fees of local laboratories and hospital laboratories are actually higher for the same services rendered by the large volume oriented labs that serve physician's offices; and

Whereas, the physician is in the position to pass some of the saving on to the patient and also save him the inconvenience of an additional trip to another office to obtain laboratory tests; and

Whereas, the third party payors recognize that the physician is entitled to a reasonable fee for this service of drawing the blood, processing the same, and interpreting the results to the patient; and

Whereas, the law is discriminatory; and

Whereas, the law will be difficult to implement; now therefore be it

RESOLVED, that The Medical Society of New Jersey seek to have the law amended to include that physicians are entitled to a reasonable and just fee for drawing, processing, and interpreting blood specimens sent to laboratories for tests; and any physician, dentist, osteopath, podiatrist, chiropractor, bioanalytical lab, or hospital lab, who refers blood or other specimens to a clinical or bioanalytical laboratory shall disclose the cost of such laboratory tests, plus a reasonable and just fee for drawing, processing, and interpreting such tests, to the patient or third party upon request of the patient or third party payor.

Foregoing "resolved" amended to read:

RESOLVED, that The Medical Society of New Jersey seek to have the law amended to require that any physician, dentist, osteopath, podiatrist, chiropractor, bioanalytical laboratory, or hospital laboratory which refers blood or other specimens to a clinical or bioanalytical laboratory shall disclose the cost of such laboratory tests to the patient or third party payors.

Adopted as amended by the House (page Tr 145)

Banquet Honoring President and Mrs. Boylan

#16

Conflict of Interest on the Part of Third Party Carrier Employees

From the Union County Medical Society

(Reference Committee "F")

Whereas, an increasing number of physicians are associated with third party carriers as paid officers and employees; and

Whereas, physicians in this category now serve as delegates and members of important committees within the framework of The Medical Society of New Jersey; and

Whereas, a conflict of interest exists, especially when such delegates from component societies openly espouse the cause of their respective third party employers in the various reference committees and on the floor of the House of Delegates of The Medical Society of New Jersey; and

Whereas, the members of the Society who are in private practice find themselves increasingly harassed and restricted by legislation and by arbitrary and capricious rulings by federal and state agencies and by third party carriers, and further find it increasingly difficult to practice with honesty, dignity, and pride because of these circumstances; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey urge and recommend that component county medical societies refrain from selecting any third party employee member of serve as a delegate to The Medical Society of New Jersey.

Rejected with notation (page Tr 147)

#17

Coordinating Alcoholism and Drug Abuse Research, Prevention, and Treatment

From the Essex County Medical Society

(Reference Committee "F")

Whereas, alcoholism has been identified as the number one health problem in the United States; and

Whereas, The Medical Society of New Jersey recognizes that research, prevention, and treatment of drug abuse and alcoholism are medical problems; and

Whereas, treatment facilities are totally inadequate for the treatment of alcoholism in the State of New Jersey, particularly for the alcoholic between ages 14-25; and

Whereas, the basic causes of alcoholism in this age group are the same as the underlying causes for drug abuse in this age group; and

Whereas, there are many more facilities available for the rehabilitation and treatment of the drug abuser than the abuser of alcohol; and

Whereas, it is economically and professionally unsound to provide for the duplication of facility when present facilities can be structured to handle both abuses; now therefore be it

RESOLVED, that The Medical Society of New Jersey espouse the policy that the two addictions of alcoholism and drug abuse in the 14-25 age group can be most satisfactorily treated through combined programs and facilities; and be it further

RESOLVED, that The Medical Society of New Jersey, to best facilitate this from an administrative level, recommend that the Division of Alcohol and the Division of Narcotics and Drug Abuse Control under the New Jersey Department of Health be combined.

Adopted (page Tr 147)

#18

Cost of Living Increase and New Jersey Hospitals

From the Essex County Medical Society

(Reference Committee "F")

Whereas, under Federal Phase IV guidelines, hospitals are entitled to cost of living increases; and

Whereas, in New Jersey, our Commissioner of Banking and Insurance and our Commissioner of Health, have arbitrarily decided to permit only five per cent increases; and

Whereas, this will either bankrupt the hospitals or result in such drastic cuts in services that our patients will suffer untold hardship; and

Whereas, our responsibility to our patients is an overriding one; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge the Commissioner of Banking and Insurance of New Jersey and the Commissioner of Health to rescind this arbitrary and devastating ruling and permit increases commensurate with Federal Phase IV guidelines.

Reference Committee offered the following substitute resolution for Resolution #18 (page Tr 147)

Substitute Resolution #18

Cost of Living Increase and New Jersey Hospitals

Whereas, hospitals are entitled to cost of living increases; and

Whereas, our responsibility to our patients is an over-riding one; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge the Commissioner of Insurance of New Jersey and the Commissioner of Health to permit cost of living increases commensurate with individual hospital evaluation and documentation.

Substitute Resolution #18 adopted (page Tr 147)

#19

Countersigning of House Officers' Hospital Orders

From the Union County Medical Society

(Reference Committee "F")

Whereas, the State Board of Medical Examiners has ruled that each order in hospitals written by a resident or intern should be countersigned by a licensed attending physician; and

Whereas, this ruling is now being enforced as part of inspections by the State Department of Health; and

Whereas, the New Jersey Hospital Association and the President of the College of Medicine and Dentistry of New Jersey have protested this ruling because it is vague and impractical in routine management of a teaching hospital; and

Whereas, unless such a ruling is more precisely defined it will certainly obstruct its objective of patient safety; now therefore be it

RESOLVED, that the Union County Medical Society urges and petitions the House of Delegates of The Medical Society of New Jersey to carefully examine this arbitrary ruling and request a conference, together with the New Jersey Hospital Association and the President of the College of Medicine and Dentistry of New Jersey, with the State Board of Medical Examiners to re-evaluate this serious problem and make every possible effort to correct its iniquities.

Adopted (page Tr 148)

#20

Generic Versus Proprietary Drugs

From the Essex County Medical Society

(Reference Committee "F")

Whereas, the generic or non-proprietary name of a drug refers to the active chemical ingredient of the drug and not to the finished product which is supplied to the patient; and

Whereas, in order that it may be dispensed, the trade-name manufacturer, by way of a specific formulation, processes the drug to its final form; and

Whereas, a manufacturer's preparation of a tablet form of a drug may contain many variables such as the crystalline size, the nature of the excipients, the coloring agents and flavors, the tableting pressures, coating films, and the orientation within the tablet; and

Whereas, the same generic chemical classification of a compound may emerge in any one

of several forms, it becomes apparent that a generic-named drug supplied by one manufacturer may differ to a significant degree from the same generic-named drug supplied by another; and

Whereas, if the physician is compelled to prescribe by generic name, he would have no control as to which drug is used by the pharmacist in filling the prescription; and

Whereas, the coating, the disintegration time, the solubility, the choice of vehicle or base, and other factors may be extremely important to the physician who selects a drug for a specific reaction in his patient; and

Whereas, the myth of "generic equivalence" was exploded long ago and there is as much difference between drugs with the same generic name as there is between people with the same family name, and in the market place there are high-quality products and low-quality products and many grades in between; and

Whereas, medical, pharmaceutical, and other scientific annals, extending back more than twenty years, contain many convincing reports of investigations which persistently support the contention that generic identity does not necessarily assure equal therapeutic effectiveness; and

Whereas, successive refills of the same prescription with products of different manufacturers could lead to variations in therapeutic response which may mislead the doctor and not be in the best interest of the patient; and

Whereas, patients may attempt to hold physicians responsible for reactions to drugs which are substituted for the originally prescribed drugs; and

Whereas, generic prescribing would not necessarily result in a saving to the patient, because it would allow the pharmacist to furnish the patient with the manufactured drug he has chosen, which might be more or less expensive than the brand-name the physician would have selected; now therefore be it

RESOLVED, that the treating physician should have the choice (in all private paid, insurance paid, and government paid programs) of deciding whether or not to prescribe generically or by brand-name; and be it further

RESOLVED, that The Medical Society of New Jersey support the policy of freedom of choice of drugs by the physician in order to enable him to best serve his patients; and be it further

RESOLVED, that this resolution be sent to all appropriate legislators if and when legislation or regulations on generic prescribing or substitution are being considered; and be it further

RESOLVED, that this resolution be forwarded to all "legislative keymen" in New Jersey if bills contrary to this viewpoint are before the New Jersey legislature.

Adopted (page Tr 148)

Dr. Richard E. Lang, President, New Jersey Foundation for Health Care Evaluation

#21

Medicaid Fee Schedule

From the Hudson County Medical Society

(Reference Committee "F")

Whereas, it is recognized that Medicaid services in New Jersey are not paid on an equal fee for equal service basis; and

Whereas, we have been advised that Medicaid in New Jersey utilizes a system of fees based on a Blue Shield schedule; and

Whereas, the representatives of Medicaid are in favor of an equal fee for equal service reimbursement; and

Whereas, at the inception of the Medicaid program in our State, representatives of The Medical Society of New Jersey recommended the utilization of the principles of a fee schedule which was not based on equal fee for equal service; now therefore be it

RESOLVED, that The Medical Society of New Jersey request reconsideration and renegotiation with Medicaid for the implementation of a 100 per cent equal fee for equal service concept.

Rejected with comment (page Tr 148)

#22

Methadone Maintenance

From the Essex County Medical Society

(Reference Committee "F")

Whereas, methadone maintenance is an accepted treatment modality for heroin addiction and federal guidelines are applied to the services rendered by a methadone maintenance clinic to include the administration of methadone, social services, physical and mental evaluation directed toward the total rehabilitation of the heroin addict within a period of two years, except for special cases approved by the Food and Drug Administration; and

Whereas, the State of New Jersey Department of Health operates an adequate number of methadone maintenance clinics through its Division of Narcotics and Drug Abuse Control; and

Whereas, these clinics are distributed throughout the State and staffed by trained personnel for a full range of rehabilitation services; and

Whereas, methadone has become a subject of abuse, often leading to death; and

Whereas, it is imperative that, in the interest of health, the number of methadone maintenance clinics in the State of New Jersey be limited and under a central control agency such as a Division of Narcotics and Drug Abuse Control; and

Whereas, although it is legal for a properly licensed private physician to put addicts on a methadone program, this leads to a lack of

control and the necessary cross-indexing of methadone patients; and

Whereas, it is not in the best interest of the addict to receive this specific type of treatment without it being integrated with a full range of rehabilitative care; now therefore be it

RESOLVED, that The Medical Society of New Jersey instruct its members that it is not in the best interest of patient care for individual physicians to request permission from the Bureau of Narcotics and Dangerous Drugs to operate their own methadone maintenance program.

Adopted (page Tr 148)

1st Vice President John J. McGuire

President Matthew E. Boylan

#23

Primary Peer Review by Third Parties

From the Essex County Medical Society

(Reference Committee "F")

Whereas, more and more third party payors, e.g. Blue Shield, Medicare, etc., are practicing medicine by computer or "clerk"; and

Whereas, this deprives the patient of payments truly due him; and

Whereas, in order to protect the patient, the physician is forced to engage in endless correspondence with these third party payors before they rectify their errors; and

Whereas, this consumes endless time of the physician and of the third party payor and causes a further rise in the cost of medical care; and

Whereas, this also has a very deleterious effect on the doctor-patient relationship; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge primary peer review by the third party payor, thereby eliminating several review steps resulting in decreased cost and a better patient-physician-insurer climate.

Adopted (page Tr 148)

#24

School of Professional Psychology

From the Essex County Medical Society

(Reference Committee "F")

Whereas, the State of New Jersey Department of Higher Education is in the process of creating a School of Professional Psychology; and

Whereas, such a school would produce personnel qualified for licensure in clinical psychology, practicing psychiatric modalities in an unsupervised fashion; and

Whereas, The Medical Society of New Jersey's Council on Mental Health has persistently opposed such practice; and

Whereas, The Medical Society of New Jersey took active opposition to S-325, the practicing psychology licensing act; and

Whereas, the New Jersey Psychiatric Association actively opposes such a school; now therefore be it

RESOLVED, that The Medical Society of New Jersey actively oppose the formation of a School of Professional Psychology.

Adopted (page Tr 148)

#25

Committee to Investigate Tissue Banks

From the Salem County Medical Society

(Reference Committee "G")

Whereas, certain individuals, mainly patients, personnel of industry, etc., in our vicinity have asked where tissue banks are located in this area so that they may "will" certain organs to them upon their death; and

Whereas, inquiries to our State Headquarters and also to the AMA have brought forth no information to answer these inquiries; now therefore be it

RESOLVED, that a committee be appointed by MSNJ; and be it further

RESOLVED, that this committee investigate and compile a list of various tissue banks and their location to be available to physicians who may require various organs for surgical transplantation and to others who wish to donate certain organs upon their demise.

Referred to Board of Trustees for implementation upon recommendation of Reference Committee (page Tr 149)

#26

Dates of the Convention of The Medical Society of New Jersey

From the Union County Medical Society

(Reference Committee "H")

Whereas, attendance by delegates of component societies at the annual convention has been decreasing over the past several years; and

Whereas, non-delegate members of The Medical Society of New Jersey who frequently attended the convention to participate in the scientific and social aspects no longer attend in large numbers; and

Whereas, the Committee on Annual Meeting has planned the annual convention to occur on the weekend of Mother's Day for the next four years; and

Whereas, Mother's Day is a quasi-American holiday which many physicians plan to spend with their wives, children, and parents; and

Whereas, Atlantic City is not conveniently within commuting distance of the bulk of the physician population of New Jersey; now therefore be it

RESOLVED, that the House of Delegates request that the Committee on Annual Meeting schedule all future meetings of The Medical Society of New Jersey on other than the Mother's Day weekend; and be it further

RESOLVED, that the House of Delegates instruct the Committee on Annual Meeting to attempt to renegotiate with the Chalfonte-Haddon Hall management to change the dates of the presently committed meetings from Mother's Day weekend to alternate dates.

Adopted with notation (page Tr 151)

#27

Repeal of P.L. 92-603 (PSRO Law)

From the Burlington County Medical Society

(Reference Committee "B")

Whereas, P.L. 92-603 (PSRO Law) was passed in opposition to the needs and desires of the medical profession and their patients; and

Whereas, effective means of implementing peer review, utilization, and health care evaluation in the State of New Jersey have been instituted by the establishment of the New Jersey Foundation for Health Care Evaluation and the Southern New Jersey PSRO; and

Whereas, the American Medical Association and other responsible physician groups are striving to amend the current PSRO legislation and will appear before the Senate Finance Committee in April 1974 for formal hearings regarding these amendments; now therefore be it

RESOLVED, that the members of the Burlington County Medical Society agree in prin-

ciple that P.L. 92-603 (PSRO Law) does not reflect the needs and desires of the medical profession and their patients; and be it further

RESOLVED, that the members of the Burlington County Medical Society support the efforts of the American Medical Association and other responsible physician groups in bringing about repeal or amendment of P.L. 92-603 (PSRO Law); and be it further

RESOLVED, that the members of the Burlington County Medical Society continue to support the ethical practice of medicine in the State of New Jersey, and to support the efforts of the New Jersey Foundation for Health Care Evaluation and the Southern New Jersey PSRO in bringing about advances in peer review, health care delivery, and effective utilization of health care facilities; and be it further

RESOLVED, that copies of these resolutions be forwarded to the President of The Medical Society of New Jersey, the presidents of each of the component county medical societies in New Jersey, and to the House of Delegates of The Medical Society of New Jersey, with a request that they support these concepts and participate in efforts to bring about repeal or amendment of P.L. 92-603 (PSRO Law), and that this be accomplished prior to the Annual Meeting of The Medical Society of New Jersey, May 11-14, 1974; and be it further

RESOLVED, that the Committee to Determine the Desirability of Supporting PSRO's by the Burlington County Medical Society be allowed to continue to function until the fate of PSRO's in the State of New Jersey is finally decided.

Rejected with notation (page Tr 142)

#28

Repeal of A-2317

From the Monmouth County Medical Society

(Reference Committee "E")

Whereas, Assembly Bill #2317 is now a New Jersey State Law; and

Whereas, this represents a serious intrusion of government on the medical practitioner; and

Whereas, this is discriminatory legislation, first by singling out the medical profession to disclose cost of laboratory work to the patient, and secondly by requiring only physicians to disclose costs and not requiring laboratories and hospitals to do the same; and

Whereas, this legislation may actually escalate the cost of medical care rather than accomplish its intent to reduce cost; now therefore be it

RESOLVED, that The Medical Society of New Jersey immediately seek the repeal of A-2317.

Rejected as contrary to 1973 House action approving A-2317 (c. 322 P.L. 1973) (page Tr 146)

#29

Establishment of Compulsory Membership in the American Medical Association

From the Bergen County Medical Society

(Reference Committee "A")

Whereas, it is imperative that the support of the medical profession voiced through the American Medical Association on the national level should be as vigorous as possible; now therefore be it

RESOLVED, that membership in the American Medical Association be established as a condition for continued membership in The Medical Society of New Jersey and its federated county medical societies.

Adopted (page Tr 139)

#30

Position Statement on Psychology

From the Bergen County Medical Society

(Reference Committee "F")

RESOLVED, that the following statement be accepted as reflecting the current position and policy of The Medical Society of New Jersey, overriding any contrary policy statements or endorsements in the mental health area made by any Society body since the 1973 session of the House of Delegates:

The Medical Society of New Jersey once again states its belief that psychotherapy, when used in treating a patient who is mentally and/or physically ill, is a technique that properly belongs only within the practice of medicine. We believe that, in the public interest, any sick person should have the opportunity to be treated by a physician, comprehensively trained to utilize a wide variety of diagnostic and treatment techniques. We do see the propriety and usefulness of non-medical mental health professionals, working in a medical setting and under medical supervision as part of a treatment team, treating patients, but we feel it inappropriate for a person whose training is based on a single technique and on a concept that denies the unity of mind and body to function *independently* in diagnosing and treating patients.

For these reasons, the Society has opposed, and continues to oppose, "the unsupervised practice of psychiatric modalities, including psychotherapy, by persons not licensed to practice medicine and surgery." (Council on Mental Health minutes of March 31, 1971, approved by the Board of Trustees at its April 18, 1971 meeting.) For these same reasons, the Society opposes any endorsement of the creation of a School of Professional Psychology as part of the College of Medicine and Dentistry of New Jersey.

Additionally, the Society would be most concerned with the confusion fostered in the public mind by a School of Professional Psychology being part of a medical college complex. To do so would confront the public with graduates of such a school, functioning independently in private practice and in clinics,

carrying the title of "Doctor" and displaying a diploma indicating their graduation from the College of Medicine and Dentistry of New Jersey. Many people would conclude that they are being treated by physician psychiatrists, trained broadly in the holistic concepts of medicine and psychiatry, rather than by psychologists, trained more narrowly and less completely.

Adopted (page Tr 148)

Board of Trustees—1974-1975

#31

Energy Crisis

From the Bergen County Medical Society

(Reference Committee "G")

Whereas, the members of the Bergen County Medical Society have labored to improve ambient air quality as a step in enhancing the health of the public; and

Whereas, their efforts aided in the promulgation of codes restricting the level of sulphur in fossil fuels used in New Jersey; and

Whereas, due to the energy crisis, cleaner fuels are in short supply; and

Whereas, critical shortages will still be a problem for some years to come; and

Whereas, we have goodly supplies of high sulphur fossil fuel; and

Whereas, technical equipment has been developed which will remove sulphur from the stack gases and will provide useful by-products such as sulphuric acid and others; and

Whereas, variances are being granted to temporarily use "dirty fuels"; now therefore be it

RESOLVED, that such variances, if and when granted, be given only when the grantee agrees to the prompt initiation of installation of the best available equipment which will reduce the amount of sulphur and particulates emitted into the air.

Amended by the Reference Committee by inserting "and be it further" at the end of the above "resolved" and the addition of a second "resolved" to read:

RESOLVED, that a copy of this resolution be sent to the Department of Public Utilities, the Department of Environmental Protection, and the Governor.

Adopted as amended by the Reference Committee (page Tr 149)

#32

Arbitration in Malpractice Cases

From the Bergen County Medical Society

(Reference Committee "C"

Whereas, the increasing number of medical malpractice actions directly affects the cost of medical care and adversely influences medical practice; and

Whereas, many of these cases are frivolous; and

Whereas, lay juries hearing these cases are not truly peers of the physician defendant since they are forced to deal with technical questions beyond their comprehension; and

Whereas, the question of investigating the feasibility of creating a medico-legal panel system and adjudicating medical negligence claims has been brought to The Medical Society of New Jersey by the New Jersey bench and bar; and

Whereas, The Medical Society of New Jersey Board of Trustees has expressed disinterest in removing these cases from the jury system; now therefore be it

RESOLVED, that the Bergen County Medical Society strongly favors a study of methods of adjudication of malpractice claims outside of the jury system as proffered by the New Jersey Supreme Court to a joint committee of physicians and legal experts.

Rejected with notation (page Tr 143)

#33

Temporary Limited Licensure

From the Bergen County Medical Society

(Reference Committee "D")

Whereas, the State Board of Medical Examiners has decreed that all orders and progress records made by non-licensed interns and residents on teaching hospital charts be countersigned by an attending physician; and

Whereas, the attending physicians and hospitals involved in teaching programs are subject to censure and punishment if they do not conform; and

Whereas, such a decree imposes a hardship on teaching attendings and takes an appreciable time from their teaching schedules and results in the loss of individual experience for residents and interns as deemed necessary in a good teaching program by certifying bodies; and

Whereas, this problem has been brought to the attention of the State Board of Medical Examiners by several organizations such as the New Jersey Hospital Association and the College of Medicine and Dentistry of New Jersey and this has not resulted in any relief; now therefore be it

RESOLVED, that The Medical Society of

New Jersey and its Board of Trustees use every means at its disposal including injunction, if necessary, to obtain immediate help for the teaching program; and be it further

RESOLVED, that The Medical Society of New Jersey and its Board of Trustees contact appropriate legislators to encourage the sponsoring of new laws to make is possible for interns and residents who have passed their E.C.F.M.G. examinations and who are in certified teaching programs to obtain temporary limited licensure for the purpose of practicing within these certified hospitals.

Amended by the Reference Committee by deletion of the above "resolveds" and the substitution of the following single "resolved:"

RESOLVED, that the State Board of Medical Examiners be requested to review its thinking in this matter and actively seek the cooperation of The Medical Society of New Jersey and all other interested parties in developing a more efficient mechanism for attesting to supervision of house staff physicians by attending physicians.

Adopted as amended by the Reference Committee (page Tr 144)

#34

Establishment of a Physicians' Bill of Rights

From the Bergen County Medical Society

(Reference Committee "A")

Whereas, a more beneficial physician-patient relationship will result when each party is aware of the rights and obligations of the other; and

Whereas, on February 6, 1973, the House of Delegates of the American Hospital Association approved a Patients' Bill of Rights; and

Whereas, the patient, as well as the American Hospital Association, should become aware of the physicians' rights in the physician-patient transaction; now therefore be it

RESOLVED, that this House of Delegates adopt the attached Physicians' Bill of Rights as its official policy; and be it further

RESOLVED, that this statement be communicated through the American Medical Association to insurance companies, hospitals, and to the patients.

Physicians Bill of Rights

1. Right to prescribe medication for my patients.

2. Right to determine if hospitalization is indicated.

3. Right to determine the course of treatment.

4. Right to use new treatments, with the patient's informed consent.

5. The freedom and responsibility to consult with my colleagues and use available medical knowledge in effecting the above actions.

6. Freedom from bureaucratic or other restraints and impositions affecting the care of patients.

7. Freedom from financial responsibility for a patient's hospitalization.

8. Freedom from the influence of insurance companies attempting to set fees and patterns of care, be they governmental or non-governmental.

9. Right to be judged by local peers in all matters pertaining to medical care.

10. Right to earn a living commensurate with my labor, training, and responsibilities.

11. Right to a confidential doctor-patient relationship.

12. Right to engage in the private practice of medicine.

Adopted (page Tr 139)

#35

Hospital Facility for Rutgers Medical School

From the Middlesex County Medical Society

(Reference Committee "D")

Whereas, the Rutgers Medical School has established itself at Piscataway, New Jersey; and

Whereas, the school has always anticipated the building of a hospital facility for the use of its students; and

Whereas, it is not feasible or desirable for the medical school to use the community hospitals as a primary teaching and referral type facility; and

Whereas, considerable progress and money has already been spent in the planning of this facility; now therefore be it

RESOLVED, by The Medical Society of New Jersey that a hospital facility be built on the campus in Piscataway, New Jersey, for the use of the Rutgers Medical School.

Adopted (page Tr 145)

Officers' Dinner—President-Elect Rogers and President Boylan

#36

Enlargement of the Medical Student Body at the College of Medicine and Dentistry of New Jersey

From the Middlesex County Medical Society

(Reference Committee "D")

Whereas, the College of Medicine and Dentistry of New Jersey has requested the American Medical Association to approve and increase in the number of medical students which the College is authorized to admit; and

Whereas, the College contracts with the Jersey City Medical Center for the training of medical students, interns, and residents, and has ample physical facilities to train additional students; and

Whereas, representatives of the American Medical Association have not reported on a reinspection of the College, made at its request for approval of enlargement of the medical student body; now therefore be it

RESOLVED, that The Medical Society of New Jersey give favorable consideration to the enlargement of the student body at the College of Medicine and Dentistry of New Jersey and that the Governor be requested to use his good offices to obtain approval of the application.

Adopted (page Tr 145)

President Boylan and Dr. James W. McKenzie, Dean, Rutgers Medical School, CMDNJ

President Boylan and Dr. Edward A. Wolfson, Associate Dean, New Jersey Medical School, CMDNJ

#37

Conflict of Interest on the Part of Members of the Board of Trustees of the Medical Society of New Jersey

From the Union County Medical Society
(Reference Committee "A")

Whereas, the Board of Trustees of The Medical Society of New Jersey bears an essential and significant responsibility for the conduct of the affairs of the Society; and

Whereas, the Board of Trustees of The Medical Society of New Jersey exerts considerable influence over the professional lives of its physician members and must be prepared to act on vital issues that affect the relationship of The Medical Society of New Jersey to third party carriers, HEW, and other government agencies; and

Whereas, those physicians serving as members of the Board of Trustees should have no other interest which could conceivably represent a source of conflict of interest; now therefore be it

RESOLVED, that the House of Delegates recommend that no physician employed on a full-time basis by a third party payor be permitted to serve as a member of the Board of Trustees of The Medical Society of New Jersey.

"Give an account of thy stewardship. No servant can serve two masters, for either he will hate one and love the other, or else he will hold to the one and despise the other."

St. Luke, Chapter 16, 13th verse.

Rejected with notation (page Tr 140)

#38

Medically Indicated Abortion Reimbursement

Harry W. Kingslow, M.D., Delegate, Essex County
(Reference Committee "F")

Whereas, recent newspaper articles have outlined controversy on the abortion issue in the State of New Jersey regarding third-party payment sources and Medicaid payment for medically indicated abortions; and

Whereas, the medical indications for such a procedure have been previously approved by The Medical Society of New Jersey's House of Delegates through resolution; and

Whereas, women should not be denied this procedure through arbitrary exclusion of third-party payment guidelines; now therefore be it

RESOLVED, that The Medical Society of New Jersey actively support the right of all women to receive third-party payments for this procedure where medical indications mandate the necessity for its performance.

Foregoing "resolved" amended by the House to read:

RESOLVED, that The Medical Society of New Jersey actively support the right of all women to receive third-party payments for abortion.

Adopted as amended by the House (page Tr 148)

#39

Opposition to Tocks Island Dam Project

Gerald H. Rozan, M.D., Delegate, Passaic County

(Reference Committee "G")

Whereas, the Tocks Island Dam Project on the Delaware River is intended to provide flood control, water supply, hydroelectric power and recreation of which recreation is the major benefit; and

Whereas, the quality of water in the Tocks reservoir is vital to recreation and water supply; and

Whereas, the President's Council on Environmental Quality and the Environmental Protection Agency have emphasized concern over the likelihood of accelerated control eutrophication caused by the upstream drainage from poultry and dairy farms and the discharge of inadequately treated sewage into the reservoir; and

Whereas, excess eutrophication will result in widespread algal blooms and scum known to be the cause of death in mammals and fish and severe gastrointestinal distress in humans; and

Whereas, the upstream runoff of chicken effluent may also lead to contamination with salmonella baccilli and result in the spread of communicable disease; and

Whereas, downstream water quality may also be adversely affected; and

Whereas, the upper Delaware is relatively unpolluted now and eutrophication has not been a problem because the free-flowing river is self-cleansing and flows out to sea; and

Whereas, there is substantial evidence that each function of the Tocks Island Dam can be accomplished by alternative measures without construction of a dam and which would not cause significant environmental damage; and

Whereas, the responsible governmental agencies have not adequately studied proposed alternatives; now therefore be it

RESOLVED, that The Medical Society of New Jersey oppose the Tocks Island Dam Project until such time as all environmental issues have been satisfactorily resolved.

Resolution amended by Reference Committee by addition of a final "resolved" which reads:

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey be directed to communicate our position to the Governor, the Department of Environmental Protection, and other appropriate agencies.

Adopted as amended by the Reference Committee (p. Tr 150)

Joseph L. McGahn, M.D., Senator from Atlantic County
Addressing House of Delegates

REFERENCE COMMITTEES

Reference Committee on Constitution and Bylaws

Donald T. Akey, M.D., Chairman

Reference Committee on Constitution and Bylaws met on Saturday, May 11, 1974, with the following members present: Doctors Harold L. Colburn, Jr., Merton L. Griswold, Raymond A. McCormack, Jr., and the chairman. Doctor Irving R. Hayman was unable to attend. Approximately 10 delegates and members were present to discuss the various items under consideration.

Revision of Constitution and Bylaws (page Tr 51)

Proposed Amendment to the Bylaws—Qualifications of Members

Mr. Maressa explained to the Committee members that a declaration of intent to become a citizen is filed with the United States Immigration Service and that the New Jersey Bar Association still requires citizenship.

The Committee **recommends** that the amendment be adopted.

Adopted

The Committee **reecommends** that the report of the Standing Committee on Revision of Constitution and Bylaws be filed.

Adopted

Reference Committee "A"

Carl A. Restivo, M.D., Chairman

Reference Committee "A" met on Saturday, May 11, 1974, with all members present: Doctors Dexter B. Blake, Warren E. Crane, Sherman Garrison, Roger C. Laauwe, and the chairman. Approximately 36 delegates and members were present to discuss the various items under consideration.

1. **President** (page Tr 5)

The President in his year of office demonstrated diligence and leadership. The Committee wishes to thank the President for his dedicated service.

The Committee **recommends** that the report be filed.

Adopted

2. **Board of Trustees** (page Tr 15)

The introductory portion of this report, covering the general activities of the Board, was reviewed and approved.

The Committee **recommends** that this portion of the report be filed.

Adopted

a. **Ad Hoc Committee to Study Apportionment of Delegates** (page Tr 15)

The Committee **recommends** that the report be filed.

Adopted

b. **Committee on Long Range Planning and**

Development (page Tr 16)

The Committee **recommends** that the report be filed.

Adopted

c. **Investigation of "Medical Centers" or "Health Centers"** (page Tr 16)

It was felt that the duty of the county medical societies was to bring to the Board of Trustees' attention the presence of the so-called "store-front clinics" and that the Board of Trustees should continue to make progress in attempting to close these clinics by reporting them to the State Board of Medical Examiners.

The Committee **recommends** that the report be filed.

Adopted

d. **Joint Conference of Presidents and Presidents-Elect of Component Societies** (page Tr 16)

The Committee **recommends** that the report be filed.

Adopted

e. **MSNJ Board Meetings—Invited Guests** (page Tr 17)

The Committee **recommends** that the report be filed.

Adopted

f. **Workshop Conference—Component Society Executives** (page Tr 17)

The Committee **recommends** that the report be filed.

Adopted

g. **Ad Hoc Committee to Investigate the Nominating Procedure—Supplemental** (page Tr 22)

Those present at the reference committee meeting, after listening to much discussion, felt that the present nominating procedure of each county submitting curriculum vitae of those members who will be running for office should be continued.

The Committee **recommends** that the report be filed.

Adopted

h. **Liaison to the New Jersey Hospital Association—Supplemental** (page Tr 22)

The Committee **recommends** that the report be filed.

Adopted

3. **Secretary** (page Tr 7)

It was announced at the reference committee meeting that this was Doctor Albright's last term as Secretary of The Medical Society of New Jersey. The Committee, delegates, and members of MSNJ expressed their sincere thanks and appreciation to Doctor Albright for the many years of devoted service.

The Committee **recommends** that the report be filed.

Adopted

4. **Judicial Council** (page Tr 24)

The Committee noted with interest Opinion #2 contained in this report. There appears to be a serious question about the advisability of adopting such a posture.

Your Committee, therefore, requests, with the concurrence of the Judicial Council, that Opinion #2 be reconsidered.

The Committee **recommends** that the report be filed.

Adopted

5. **Executive Director** (page Tr 27)

The Committee **recommends** that the report be filed.

Adopted

6. **Credentials** (page Tr 34)

The Committee **recommends** that the report be filed.

Adopted

7. **Resolutions:**

a. **Apportionment of MSNJ's House of Delegates**—Resolution #1 (page Tr 110)

The Committee was informed of three facts:

1. The Constitution and Bylaws of The Medical Society of New Jersey limit the number of delegates to 400;

2. The larger counties do not have 100 per cent attendance at the House of Delegates' meetings; and

3. The smaller counties that have three delegates are only five in number.

If the total number of delegates of each of the smaller counties is increased to six to give them more responsibilities and more qualified individuals to serve The Medical Society of New Jersey (a total increase of 15 delegates (3x5) to the smaller counties) the decrease of 15 delegates spread over the larger counties should present no difficulties.

The Committee **recommends** that Resolution #1 be adopted.

Not Adopted

b. **Consultation with MSNJ's Councils and Committees**—Resolution #2 (page Tr 110)

The Committee felt, after listening to much discussion, that if the purpose of the resolution was to induce better liaison with the Board of Trustees and various councils and committees that represent MSNJ, the resolution should be adopted. It was noted, however, that the subject of the resolution has been accomplished and the lack of communication pointed out.

The Committee **recommends** that Resolution #2 be rejected.

Not Adopted

Resolution #2 adopted by the House

c. **MSNJ Support of Federal Gun Control Legislation**—Resolution #3 (page Tr 111)

Those present at the reference committee meeting felt that this resolution does not present a matter relevant to MSNJ concern.

The Committee **recommends** that Resolution #3 be rejected.

Not Adopted

Resolution #3 adopted by the House

d. **Use of the Physician Taxpayer Identification Number**—Resolution #4 (page Tr 111)

In discussion it was pointed out that MSNJ uses the number for identification purposes only, and does not publish it nor release it to any other organization.

The Committee **recommends** that Resolution #4 be rejected.

Not Adopted

Resolution #4 adopted by the House

e. **Establishment of Compulsory Membership in the American Medical Association**—Resolution #29 (page Tr 129)

There was much discussion and very little opposition to Resolution #29.

The Committee **recommends** that Resolution #29 be adopted.

Adopted

f. **Establishment of a Physicians' Bill of Rights**—Resolution #34 (page Tr 132)

Those present at the reference committee meeting agreed with the principle of a physicians' bill of rights. However, some of the rights, notably 6 and 8 were not understood

fully by the committee since the sponsor of the resolution was not present to explain them.

The Committee **recommends** that Resolution #34 be rejected.

Not Adopted

Resolution #34 adopted by the House

g. **Conflict of Interest on the Part of Members of the Board of Trustees of The Medical Society of New Jersey** — Resolution #37 (page Tr 135)

After much heated and eloquent oratory the majority of those present felt that this resolution, although stated not to be directed against any one in particular, should not be adopted. It was felt, since all members of the House of Delegates vote for the Board of Trustees, that the decision of the House of Delegates would be to select the best-qualified individuals to serve The Medical Society of New Jersey to the best of their ability. It was further noted that many physicians are quite properly involved in outside organizations and this does not present a conflict of interest.

The Committee **recommends** that Resolution #37 be strongly rejected.

Adopted

Reference Committee "B"

Elbert H. Pogue, M.D., Chairman

Reference Committee "B" met on Saturday, May 11, 1974, with four members present: Doctors Charles Krueger, Francis A. Pflum, Leopold E. Thron, and the chairman. Dr. Blackwell Sawyer was absent. Approximately 70 members and delegates were present. Dr. Robert Stackpole acted as sergeant at arms. Dr. Max H. Parrott, a member of the Board of Trustees of the AMA, Dr. William J. Vandervort, President of the Medical Society of Delaware, and Mr. Thomas J. Crane, Administrative Director of the New Jersey Foundation for Health Care Evaluation, attended as invited guests.

Dr. Parrott addressed the audience briefly and spoke of AMA activities with regard to P.L. 92-603. He stressed the fact that a distinction should be made between "cost containment" and "quality control."

1. **Treasurer** (page Tr 8)

The Treasurer, Dr. Samuel J. Lloyd, elaborated on the written report. The Committee commends the Treasurer for his continuing excellent performance and **recommends** that the report be filed.

Adopted

2. **Finance and Budget** (page Tr 35)

The Committee **recommends** that the recommendations on pages Tr 36-37 of the annual report be approved with the exception of paragraph 3. Paragraph 3 recommends "that a special assessment be adopted at $10 per capita to serve as a grant to the New Jersey Foundation for Health Care Evaluation."

Adopted

The Committee **recommends** that paragraph 3 be rejected. It was noted that, in May of 1973, the House of Delegates approved a recommendation that a special assessment be adopted at $10 per capita to serve as a **one-time** grant to the New Jersey Foundation for Health Care Evaluation . . ." The members of this Reference Committee considered the action of the 1973 House of Delegates in making its decision.

Not Adopted—Special $10 assessment to serve as a grant to the New Jersey Foundation for Health Care Evaluation adopted.

The Committee **recommends** that the New Jersey Foundation for Health Care Evaluation seek funds for its support from the members of The Medical Society of New Jersey and the New Jersey Association of Osteopathic Physicians and Surgeons on a voluntary basis and from other sources that are or that may become available.

Not Adopted

The Committee **recommends** further that The Medical Society of New Jersey re-examine and re-evaluate the function of the New Jersey Foundation for Health Care Evaluation and its relationship to The Medical Society of New Jersey.

Adopted

The Committee **recommends** that the report be filed.

Adopted

3. **New Jersey Foundation for Health Care Evaluation** (page Tr 98) and supplement (page Tr 105)

The Committee **recommends** that the report be filed.

Adopted

4. **Medical Student Loan Fund** (page Tr 47)

The Committee **recommends** that the report be filed.

Adopted

5. **Physicians' Relief Fund** (page Tr 87)

The Committee **recommends** that the report be filed.

Adopted

6. **Publication** (page Tr 51)

The Committee **recommends** that the report be filed.

Adopted

7. **Project Hope/Vietnam** (page Tr 87)

The Committee **recommends** that the report be filed.

Adopted

8. **Resolutions:**

a. **Funding of the New Jersey Foundation for Health Care Evaluation** – Resolution #5 (page Tr 112)

The Committee **recommends** that Resolution #5 be adopted.

Not Adopted—in accordance with House approval of special $10 assessment to serve as a grant to the New Jersey Foundation for Health Care Evaluation—recommendation #3 in Finance and Budget Committee report (page Tr 37)

b. **Amendment of PSRO and Evaluation of the New Jersey Foundation for Health Care Evaluation**—Resolution #6 (page Tr 112)

The Committee recognizes that there is much of value in this resolution and the members were in unanimous agreement with the first "Resolved," but rejected the second and third "Resolved."

Therefore, the Committee **recommends** that Resolution #6 be rejected.

Not Adopted

The first "resolved" was approved by previous action (3rd paragraph, this page) and is unnecessary, the second "resolved" was rejected by action of the House, and the third "resolved" was amended to read:

RESOLVED, that The Medical Society of New Jersey actively seek to have the PSRO law amended.

Resolution #6 adopted as amended.

c. **Repeal of P.L. 92-603 (PSRO Law)**—Resolution #27 (page Tr 127)

Resolution #27 was written originally for consideration by the Burlington County Medical Society. While in agreement with much of the intent of Resolution #27, the Committee cannot recommend the resolution in its present form to the House of Delegates.

The Committee **recommends** that Resolution #27 be rejected.

Adopted

The Chairman wishes to thank the members of Reference Committee "B" and all delegates and members who participated in the discussion.

Reference Committee "C"

Daniel J. O'Regan, M.D., Chairman

Reference Committee "C" met on Sunday, May 12, 1974, with the following members present: Doctors Frank M. Galioto, Warren H. Knauer, Robert G. Salasin, and the chairman. Approximately 60 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees—Item**

MSP Board of Trustees Nominations (page Tr 17)

The Committee **recommends** that the nominations contained on page Tr 17 be approved.

Adopted

The Committee **recommends** that the report be filed.

Adopted

2. **Medical-Surgical Plan of New Jersey** (page Tr 90)

The Committee **recommends** that the report be filed.

Adopted

3. **Medical Defense and Insurance** (page Tr 39) and (page Tr 45)

Doctor Paul J. Kreutz, Mr. David Blanksteen, and Mr. Joseph Britton were in attendance to answer questions and supply information.

The Committee **recommends** that the recommendations on Tr pages 42, 44, and 45 of the annual report be approved.

Adopted

The Committee **recommends** that the report be filed.

Adopted

4. **Retirement Plan for Physicians** (page Tr 88)

Doctor Marchione discussed the report.

The Committee **recommends** that the report be filed.

Adopted

5. **Resolutions:**

a. **Action of Blue Shield of New Jersey in Reference to Other Plans Employing "Hold-Harmless" Clause**—Resolution #7 (p. Tr 113)

There was extensive discussion concerning this resolution. As a result, the Committee urges further communication between Blue

Shield of New Jersey and the physicians of New Jersey regarding fee arrangements between the doctor and the patient, including prior discussions before care is rendered, where practicable.

The Committee **recommends** that Resolution #7 be adopted.

Not Adopted

b. **Exclusion of First Fourteen Days of Life in Health Insurance Policies**—Resolution #8 (page Tr 114)

The Committee **recommends** that Resolution #8 be adopted.

Adopted

c. **Federal Catastrophic Health Insurance**—Resolution #9 (page Tr 114)

The Committee **recommends** that Resolution #9 be adopted.

Adopted

d. **Handling of Malpractice Suits**—Resolution #10 (page Tr 115)

The Reform of Medical Malpractice Law—Resolution #13 (page Tr 117)

Arbitration in Malpractice Cases—Resolution #32 (page Tr 131)

Resolutions #10, 13, and 32, having to do with malpractice suits, were considered together. There was extensive discussion of these resolutions with participation by Dr. Kreutz, Mr. Britton, and Mr. Maressa.

As a result of the discussion, the Committee **recommends** that, rather than try a new method of resolving malpractice actions, the present system involving the County Medical Review and Advisory Committee be improved and strengthened.

Adopted

Therefore the Committee **recommends** that Resolutions #10 and #32 be rejected.

Adopted

The Committee **recommends** that Resolution #13, since it proposes legislative action, be referred to the Council on Legislation, following the procedure outlined by the Board of Trustees under The Medical Society of New Jersey's policy decision.

Adopted

e. **Payment by Blue Shield for Medical Consultation in Consultant's Office** – Resolution #11 (page Tr 116)

Following discussion, the Committee felt that there was some merit in the resolution but it required further definition and study.

The Committee **recommends** that Resolution #11 be referred to the Council on Medical Services for study and report.

Adopted

f. **Rehabilitation Coverage**—Resolution #12 (page Tr 116)

As a result of the discussion, the Committee felt, as in the previous resolution, there was merit in the proposal but that because of its scope and complexity it requires further detailed analysis.

The Committee **recommends** that Resolution #12 be referred to the Council on Medical Services for study and report.

Adopted

We wish to thank those who attended and contributed to the consideration of the items and I also want to thank the members of the Committee for their assistance.

Reference Committee "D"

William A. Dwyer, Jr., M.D., Chairman

Reference Committee "D" met on Saturday, May 11, 1974, with all members present: Doctors Elmer L. Grimes, John F. Marshall, Frederick C. Steller, John S. Van Mater, and the chairman. Approximately 25 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees—Items**

a. **Development of a Medical Education Program for South Jersey** (page Tr 18)

The Committee **recommends** that the report be filed.

Adopted

b. **Logan College of Chiropractic** (page Tr 18)

The Committee **recommends** that the report be filed.

Adopted

c. **School of Allied Health Professions** (page Tr 18)

The Committee **recommends** that the report be filed.

Adopted

2. **Medical Education** (page Tr 46)

The Committee **recommends** that the report be filed.

Adopted

3. **Emergency Medical Care** (page Tr 85)

The Committee considered each item of the report separately.

Emergency Department Medical Technician Program (page Tr 85)

The Committee **recommends** that the Committee on Emergency Medical Care explore in depth with the medical staffs of the various hospitals the employment possibilities for ED EMT's prior to seeking from the Board of Medical Examiners legal authorization for their employment in the emergency department.

Adopted

Additionally, the Committee notes that the recommendations contained on Tr pages 86 and 87 of the annual report are in conflict with the report of the Committee on Finance and Budget and the monies requestd exceed what was provided for in the report of the Committee on Finance and Budget. Your Reference Committee **recommends** therefore that those recommendations contained in the annual report of the Committee on Emergency Medical Care be rejected.

Adopted

The Committee **recommends** that the report as amended by deletion of the contained recommendations be filed.

Adopted

4. **Medicine and Religion** (page Tr 87)

The Committee **recommends** that the report be filed.

Adopted

5. **Resolutions:**

a. **Temporary Limited Licensure**—Resolution #33 (page Tr 131)

The Committee **recommends** that Resolution #33 be amended and that both "RESOLVEDS" be omitted and the following "RESOLVED" be substituted in its place.

RESOLVED, that the State Board of Medical Examiners be requested to review its thinking in this matter and actively seek the cooperation of The Medical Society of New Jersey

and all other interested parties in developing a more efficient mechanism for attesting to supervision of house staff physicians by attending physicians.

Adopted as amended

b. **Hospital Facility for Rutgers Medical School**—Resolution #35 (page Tr 133)

The Committee notes that the action requested in Resolution #35 has already been accomplished.

The Committee **recommends** that Resolution #35 be adopted to indicate the continuing support of The Medical Society of New Jersey of the efforts of the College of Medicine and Dentistry of New Jersey.

Adopted

c. **Enlargement of the Medical Student Body at the College of Medicine and Dentistry of New Jersey**—Resolution #36 (page Tr 134)

The Committee notes that the action requested in Resolution #36 has already been accomplished.

The Committee **recommends** that Resolution #36 be adopted to indicate the continuing support of The Medical Society of New Jersey of the efforts of the College of Medicine and Dentistry of New Jersey.

Adopted

Reference Committee "E"

Frank R. Begen, M.D., Chairman

Reference Committee "E" met on Sunday, May 12, 1974, with the following members present: Doctors Paul J. Kreutz, Frank J. Malta, Robert A. Weinstein, and the chairman. Armando F. Goracci, M.D., was unable to attend. Approximately 32 delegates and members were present to discuss the various items under consideration.

1. **Legislation** (page Tr 54) and supplemental (page Tr 69)

Because a position of **No Action** was taken on **S-395**, it was recommended by several attending physicians that the Council on Legislation give more attention to fiscal bills and, when appropriate, take action.

The Chairman of the Council on Legislation agreed that the House should take action to change the position of **S-395** from **NO ACTION** to **APPROVAL.**

The Committee **recommends** that the position on S-395 be changed to "approved" and that the report be filed as amended.

Adopted

2. **Public Relations** (page Tr 82)

The Committee **recommends** that the report be filed.

Adopted

3. **Resolutions:**

a. **Amendment of the Lien Law Pertaining to Physicians**—Resolution #14 (page Tr 118)

The Committee **recommends** that Resolution #14 be adopted.

Adopted

b. **Laboratory Services Billing Act**—Resolution #15 (page Tr 119)

The Committee recommends that Resolution #15 be rejected, because it is contrary to the intent of the law and the action taken by the 1973 House of Delegates of The Medical Society of New Jersey.

Not Adopted

Resolution #15 adopted by the House after amending "Resolved" to read as follows:

RESOLVED, that The Medical Society of New Jersey seek to have the law amended to include that physicians are entitled to a reasonable and just fee for drawing, processing, and interpreting blood specimens sent to laboratories for tests; and any physician, dentist, osteopath, podiatrist, chiropractor, bioanalytical laboratory or hospital laboratory, who refers blood or other specimens to a clinical or bioanalytical laboratory shall disclose the cost of such laboratory tests to the patient or third party payor.

c. **Repeal of A-2317**—Resolution #28 (page Tr 128)

The Committee recommends that Resolution #28 be rejected, because it is contrary to the action taken by the 1973 House of Delegates which approved A-2317 (c.322 P.L. 1973).

Adopted

Reference Committee "F"

R. Winfield Betts, M.D., Chairman

Reference Committee "F" met on Sunday, May 12, 1974, with all members present: Doctors Alfred A. Alessi, Charles W. Boozan, Frederick J. Knocke, Robert E. Verdon, and the chairman. Approximately 60 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees—Items**

a. **Certificate of Need** (page Tr 19)

The Committee recommends that the report be filed.

Adopted

b. **Chronic Alcoholism** (page Tr 19)

The Committee recommends that the report be filed.

Adopted

c. **Equitable Composition of FDA Panel on Drug Evaluations** (page Tr 19)

The Committee recommends that the report be filed.

Adopted

d. **Fitness for Licensure** (page Tr 20)

The Committee recommends that the report be filed.

Adopted

e. **Hospital Readmission of Acute Cases** (page Tr 20)

The Committee recommends that the report be filed.

Adopted

f. **Medicaid Waiver Project** (page Tr 20)

The Committee recommends that the report be filed.

Adopted

g. **Medicare Reimbursement Refusals** (page Tr 21)

The Committee recommends that the report be filed.

Adopted

h. **School of Professional Psychology** (page Tr 21)

Since the School of Professional Psychology has already been established at Rutgers University, we feel that concern with reference to establishment of the School of Professional Psychology at the College of Medicine and Dentistry of New Jersey no longer exists.

The Committee **recommends** that the report be filed.

Adopted

2. **Medical Services** (page Tr 73)

The Committee **recommends** that the report be filed.

Adopted

3. **Occupational Health, Workmen's Compensation and Rehabilitation** (page Tr 74)

The Committee **recommends** that the report be filed.

Adopted

4. **Mental Health** (page Tr 75)

The Committee **recommends** that the report be filed.

Adopted

5. **Alcoholism** (page Tr 76)

The Committee **recommends** that the report be filed.

Adopted

6. **Drug Abuse** (page Tr 77)

The Committee noted that the Committee on Drug Abuse held no meetings this year. Because the problem of drug abuse is of such importance, the Reference Committee **recommends** that a more active Committee on Drug Abuse be appointed in order to study the matter thoroughly and present a complete report to the House of Delegates at its next session.

Adopted

The Committee **recommends** that the report be filed.

Adopted

7. **Emotional Disorders of Childhood and Adolescence** (page Tr 77)

The Committee **recommends** that the report be filed.

Adopted

8. **Mental Retardation** (page Tr 78)

The Committee **recommends** that the report be filed.

Adopted

9. **Neurological and Related Disorders** (page Tr 78)

The Committee **recommends** that the report be filed.

Adopted

10. **Resolutions:**

a. **Conflict of Interest on the Part of Third Party Carrier Employees—Resolution** #16 (page Tr 120)

The Committee **recommends** that Resolution #16 be rejected, since it is contrary to the Constitution and Bylaws of The Medical Society of New Jersey, and the resolution itself is vague and ill-defined.

Adopted

b. **Coordinating Alcoholism and Drug Abuse Research, Prevention, and Treatment**—Resolution #17 (page Tr 120)

The Committee **reecommends** that Resolution #17 be adopted.

Adopted

c. **Cost of Living Increase and New Jersey Hospitals**—Resolution #18 (page Tr 121)

Because its wording makes Resolution #18, as submitted, obsolete, the Committee **rec-**

ommends that Substitute Resolution #18 be adopted.

Whereas, hospitals are entitled to cost of living increases; and

Whereas, our responsibility to our patients is an over-riding one; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge the Commissioner of Insurance of New Jersey and the Commissioner of Health to permit cost of living increases commensurate with individual hospital evaluation and documentation.

Adopted

d. **Countersigning of House Officers' Hospital Orders**—Resolution #19 (page Tr 122)

The Committee **recommends** that Resolution #19 be adopted.

Adopted

e. **Generic Versus Proprietary Drugs**—Resolution #20 (page Tr 122)

The Committee **recommends** that Resolution #20 be adopted.

Adopted

f. **Medicaid Fee Schedule**—Resolution #21 (page Tr 124)

The Committee **recommends** that Resolution #21 be rejected because it is neither clear nor sufficiently specific.

Adopted

g. **Methadone Maintenance**—Resolution #22 (page Tr 124)

The Committee **recommends** that Resolution #22 be adopted.

Adopted

h. **Primary Peer Review by Third Parties**—Resolution #23 (page Tr 125)

The Committee **recommends** that Resolution #23 be adopted.

Adopted

Permission is requested to consider Resolutions #24 and #30 simultaneously since both deal with the same subject, with the explanation that the Committee feels that Resolution #24 is moot since the establishment of the School of Professional Psychology is already a fait accompli, and the Committee feels that the New Jersey Psychiatric Association and our psychiatrist membership are entitled to a statement policy with reference to the establishment of a School of Professional Psychology. We therefore recommend a rejection of Resolution #24 and the adoption of Resolution #30.

i. **School of Professional Psychology**—Resolution #24 (page Tr 126)

The Committee **recommends** that Resolution #24 be rejected for the following reason: A School of Professional Psychology has already been established at Rutgers University with the approval of the State of New Jersey's Department of Higher Education.

Not Adopted

Resolution #24 adopted by the House

j. **Position Statement on Psychology**—Resolution #30 (page Tr 129)

The Committee **recommends** that Resolution #30 be adopted.

Adopted

k. **Medically Indicated Abortion Reimbursement**—Resolution #38 (page Tr 135)

The Committee **recommends** that Resolution #38 be adopted.

House amended the "resolved" to read:

RESOLVED, that The Medical Society of New Jersey actively support the right of all women to receive third-party payments for abortion.

Adopted as amended by the House.

Reference Committee "G"

Robert H. Areson, M.D., Chairman

Reference Committee "G" met on Saturday, May 11, 1974, with all members present: Doctors Aldo G. Baldi, Hillel M. Ben-Asher, Joseph Bitsack, Frederick W. Durham, and the chairman. Approximately 14 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees—Items**

a. **Advisory Committee to the Office of Consumer Health Education** (page Tr 21)

The Committee **recommends** that the report be filed.

Adopted

b. **Better Protection of the Public from Food Handling Establishments Found Unsanitary** (page Tr 22)

The Committee suggests that The Medical Society of New Jersey advise the new Commissioner of Health of our concern in this matter.

The Committee **recommends** that the report be filed.

Adopted

2. **Public Health** (page Tr 79)

The committee **recommends** that the report be filed.

Adopted

3. **Cancer Control** (page Tr 79)

The committee **recommends** that the report be filed.

Adopted

4. **Child Health** (page Tr 80)

The Committee notes with concern that the chairmanship of this important committee has remained "vacant," but is hopeful this situation will be favorably resolved.

The committee **recommends** that the report be filed.

Adopted

5. **Conservation of Vision, Hearing, and Speech** (page Tr 80)

The committee **recommends** that the report be filed.

Adopted

6. **Environmental Health** (page Tr 80)

The committee **recommends** that the report be filed.

Adopted

7. **Maternal and Infant Welfare** (page Tr 81)

The committee **recommends** that the report be filed.

Adopted

8. **Resolutions:**

a. **Committee to Investigate Tissue Banks**—Resolution #25 (page Tr 126)

The Committee approved the intent of Resolution #25, but **recommends** that rather than forming a new committee the resolution be referred to the Board of Trustees for implementation.

Adopted

b. **Energy Crisis**—Resolution #31 (page Tr 130)

The Committee voted to amend Resolution #31 by the addition of a final "Resolved", which reads:

RESOLVED, that a copy of this resolution be

sent to the Department of Public Utilities, the Department of Environmental Protection; and the Governor.

The Committee **recommends** that Resolution #31 be adopted as amended.

Adopted

c. **Opposition to Tocks Island Dam Project**—Resolution #39 (page Tr 136)

The Committee voted to amend Resolution #39 by the addition of a final "Resolved," which reads:

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey be directed to communicate our position to the Governor, the Department of Environmental Protection, and other appropriate agencies.

The Committee **recommends** that Resolution #39 be adopted as amended.

Adopted

Mrs. John Abbamonte
President, Woman's Auxiliary

President Boylan and Dr. Arthur Bernstein, President, Academy of Medicine of New Jersey

House of Delegates

Reference Committee "H"

Karl T. Franzoni, M.D., Chairman

Reference Committee "H" met on Sunday, May 12, 1974, with all members present: Doctors James E. Brennan, Harry W. Fullerton, Jr., Samuel B. Pole, III, Sidney Woltz, and the chairman. Approximately 15 delegates and members were present to discuss the various items under consideration.

1. **Annual Meeting** (page Tr 28)

The effort to implement innovative changes in format is acknowledged with commendation.

The Committee **recommends** that the recommendation at the end of this report, concerning meeting dates during the 1978 Annual Meeting, be held in abeyance pending the outcome of House action concerning Resolution #26.

Adopted

The Committee **recommends** that the report be filed.

Adopted

2. **Scientific Exhibits** (page Tr 30)

The committee **recommends** that the report be filed.

Adopted

3. **Scientific Program** (page Tr 31)

The Committee **recommends** that the report be filed.

Adopted

4. **Honorary Membership** (page Tr 34)

The Committee **recommends** that the report be filed.

Adopted

5. **Woman's Auxiliary Advisory** (page Tr 53)

The Committee **recommends** that the report be filed.

Adopted

6. **Nominations for Emeritus Membership** (page Tr 107 and supplemental (page Tr 108)

The Committee **recommends** that the report be filed.

Adopted

7. **Resolution:**

Dates of the Convention of The Medical Society of New Jersey—Resolution #26 (page Tr 127)

The Committee takes cognizance of the total absence of sentiment for retention of Mother's Day weekend for the annual meeting.

The Committee **recommends** that Resolution #26 be adopted and that MSNJ actively negotiate for changes in the annual meeting dates for time other than Mother's Day weekend.

Adopted

"Hawaiian" Night

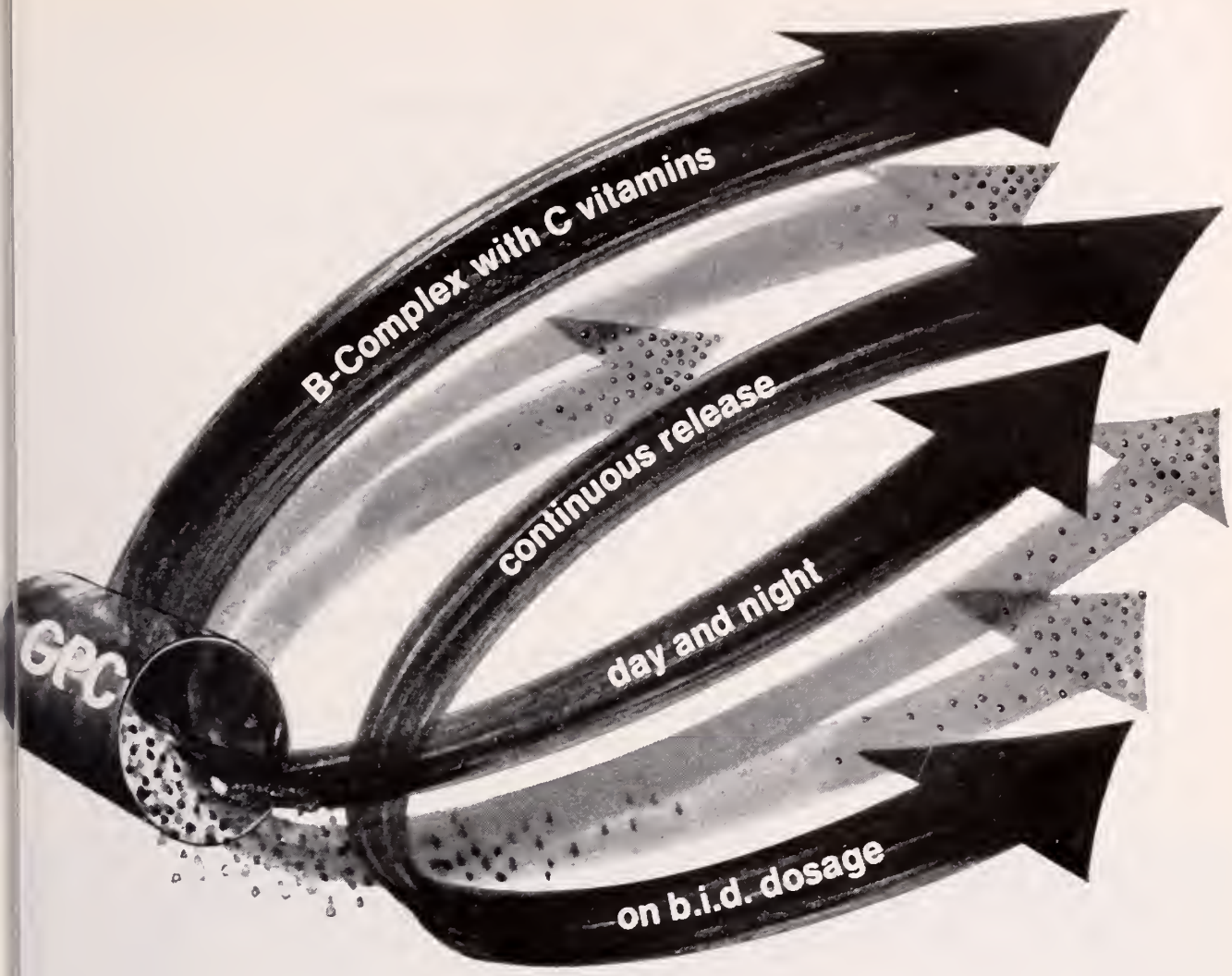
Report of the Nominating Committee and Election—May 12, 1974

William J. D'Elia, M.D., Chairman

OFFICE	TERM	NOMINEE AND COUNTY
President-Elect	1 year	John J. McGuire, M.D., Essex
1st Vice-President	1 year	John S. Madara, M.D., Salem
2nd Vice-President	1 year	Frank R. Begen, M.D., Bergen
Secretary	1 year	Charles L. Cunniff, M.D., Hudson
Treasurer	1 year	Samuel J. Lloyd, M.D., Mercer
Trustees:		
1st District	1 year	William Greifinger, M.D., Essex
1st District	3 years	George L. Benz, M.D., Essex
2nd District	3 years	James S. Todd, M.D., Bergen
2nd District	1 year	John J. Crosby, Jr., M.D., Hudson*
5th District	3 years	Sherman Garrison, M.D., Cumberland
Judicial Councilors		
2nd District	3 years	John L. Olpp, M.D., Bergen
5th District	3 years	John A. Surmonte, M.D., Salem
AMA Delegates	2 years	Frank J. Hughes, M.D., Camden
	2 years	John F. Kustrup, M.D., Mercer
	2 years	Emanuel M. Satulsky, M.D., Union
	2 years	Robert E. Verdon, M.D., Bergen
AMA Alternate Delegates:	2 years	John J. Bedrick, M.D., Hudson
	2 years	Nicholas A. Bertha, M.D., Morris
	2 years	Karl T. Franzoni, M.D., Mercer
	1 year	William J. D'Elia, M.D., Monmouth**
Delegates and Alternate Delegates to Other States		
New York:		
Delegate	1 year	Albert F. Moriconi, M.D., Mercer
Alternate	1 year	Josiah C. McCracken, M.D., Atlantic
Connecticut:		
Delegate	1 year	Edward G. Bourns, M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic
Administrative Councils		
Legislation:		
1st District	3 years	John R. Tobey, M.D., Essex
4th District	3 years	Meyer L. Abrams, M.D., Burlington
Medical Services:		
1st District	3 years	Joseph A. Lepree, M.D., Union
4th District	3 years	Charles O. Tyler, M.D., Camden
5th District	1 year	Armando F. Goracci, M.D., Gloucester
Mental Health:		
1st District	3 years	Arnold M. Kallen, M.D., Essex
2nd District	3 years	Eugene V. Resnick, M.D., Bergen
Public Health:		
1st District	3 years	George L. Erdman, M.D., Union
4th District	3 years	Frederick C. Steller, M.D., Monmouth
Public Relations:		
1st District	3 years	Frank Y. Watson, M.D., Essex
4th District	3 years	John P. Kengeter, M.D., Ocean
Standing Committees		
Annual Meeting	3 years	James H. Spillane, M.D., Warren
Finance and Budget	3 years	Charles S. Krueger, M.D., Burlington
Medical Defense and Insurance	3 years	Frank J. Malta, M.D., Ocean
Medical Education	3 years	Arthur Bernstein, M.D., Essex
Publication	3 years	Julio del Castillo, M.D., Mercer
Woman's Auxiliary Advisory	3 years	Frederick W. Durham, M.D., Camden

* Nominated and elected by the House to fill unexpired term of Charles L. Cunniff, M.D., who was elected Secretary.

** Nominated and elected by the House to fill unexpired term of Robert E. Verdon, M.D., who was elected AMA Delegate.



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Vitamin B-6 (Pyridoxine)	5 mg
Niacinamide	50 mg
Calcium Pantothenate	10 mg
Vitamin C (Ascorbic Acid)	300 mg
Vitamin B-12 (Cyanocobalamin)	5 mcg

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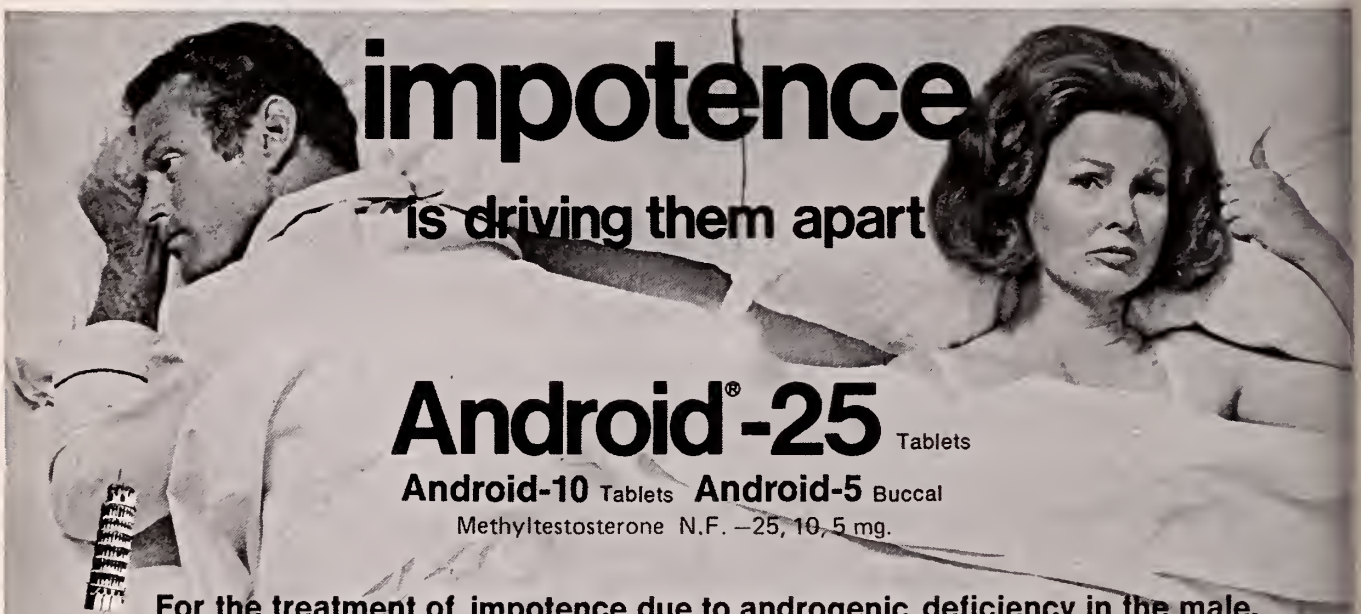

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Official Attendance Report

County	Delegates	Members	Total
Atlantic	10	46	56
Bergen	29	36	65
Burlington	10	19	29
Camden	23	41	64
Cape May	3	4	7
Cumberland	5	16	21
Essex	65	126	191
Gloucester	5	8	13
Hudson	25	28	53
Hunterdon	3	2	5
Mercer	25	43	68
Middlesex	22	23	45
Monmouth	19	48	67
Morris	19	36	55
Ocean	8	22	30
Passaic	32	40	72
Salem	3	8	11
Somerset	6	11	17
Sussex	3	3	6
Union	32	37	69
Warren	2	4	6
Fellows and Officers	22	—	22
	371	601	972

Physician Guests	64
Physician Exhibitors	15
TOTAL PHYSICIAN REGISTRATION	1,051
Auxiliary	349
Visitors	445
Exhibitors	230
TOTAL REGISTRATION	2,075

REGISTRATION OF HOUSE OF DELEGATES

Registration:	
Total Possible—Officers and Fellows	27
Total Possible—County Delegates	392
Total 1974 House of Delegates	419
Total Officers and Fellows Registered	22
Total County Delegates Registered	349
Total Registered	371
Attendance at House Sessions:	
1st Session, 5/11/74	296
2nd Session, 5/12/74	342
3rd Session, 5/13/74 Part I	340
5/14/74 Part II	307
Average for All Sessions	321

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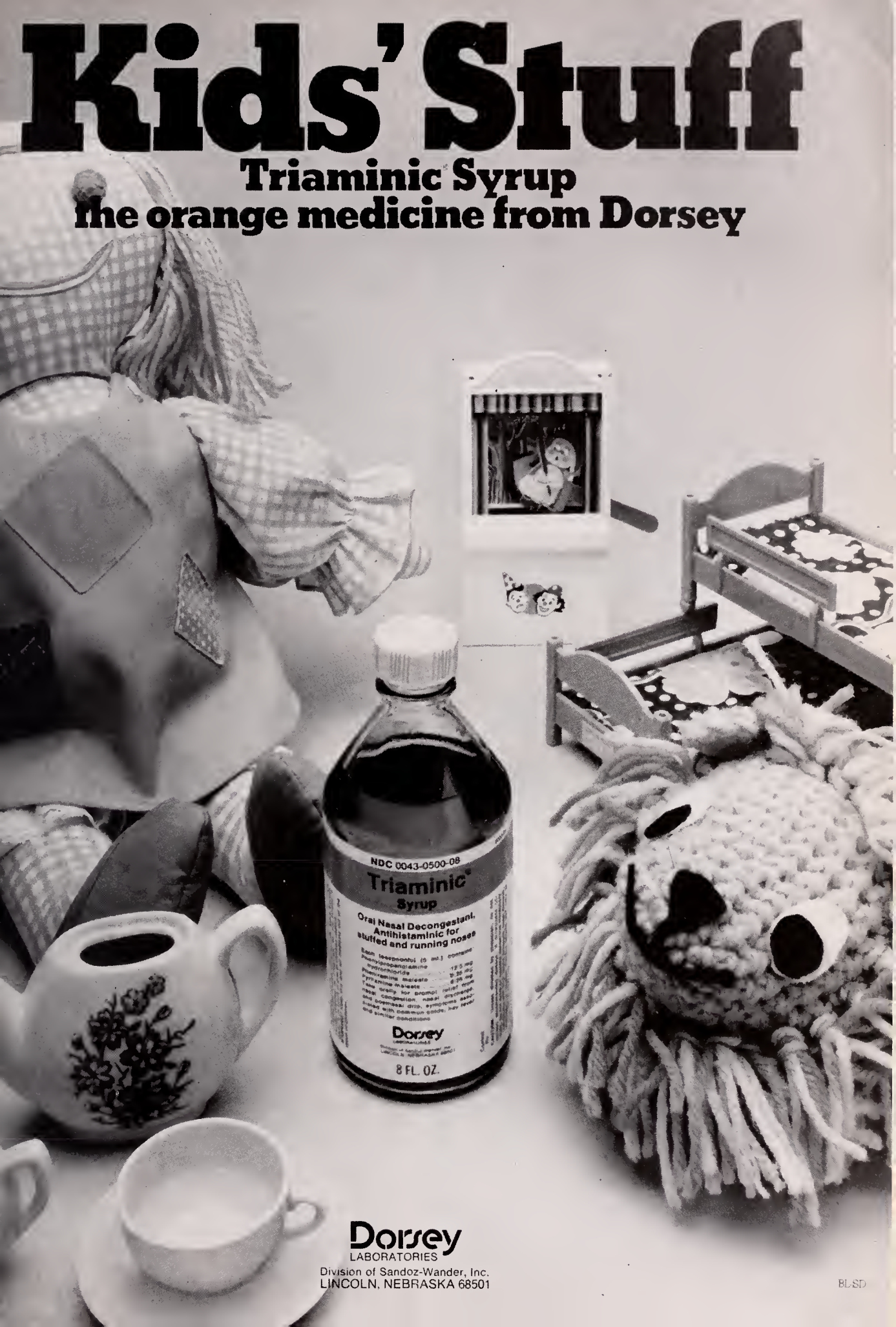

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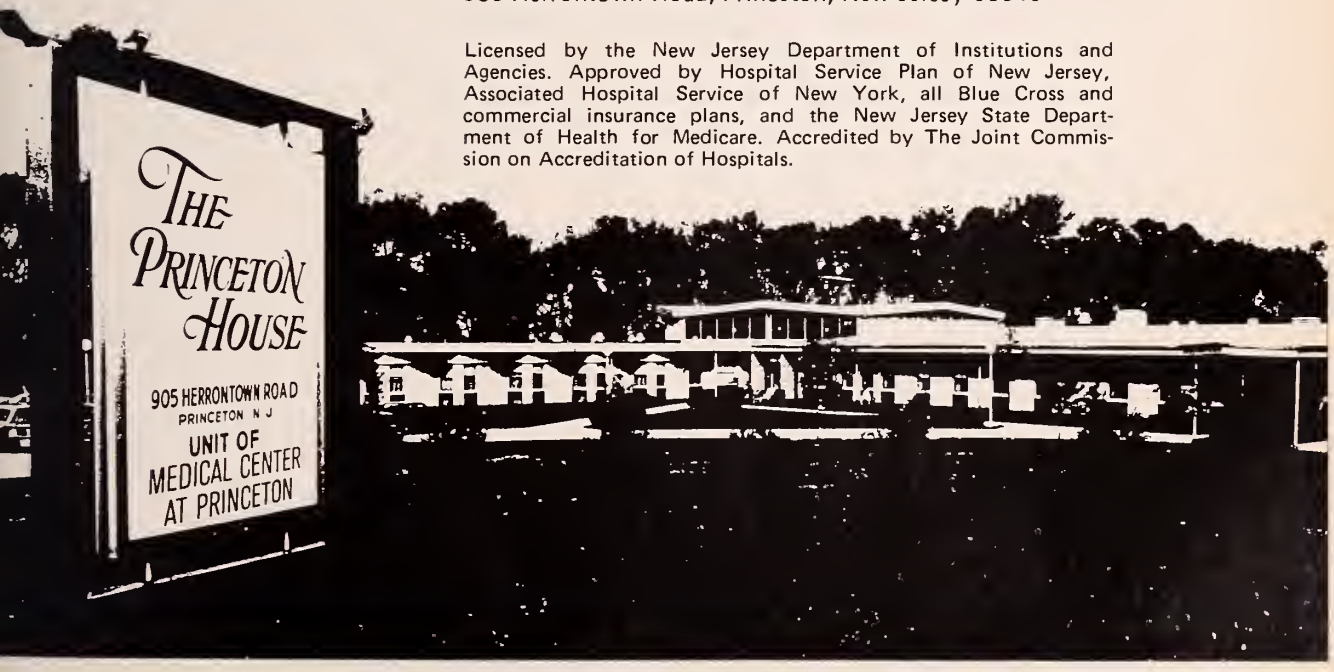

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

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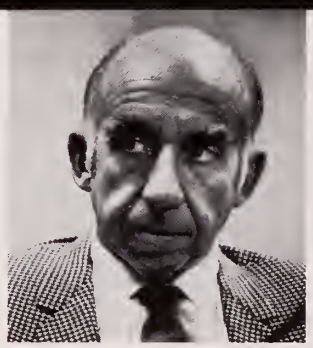
The Role of the Detail Man

"I may be prejudiced, but I a very much in favor of the detail me I meet. Most of them are knowledg able about the drugs they promote and can be a great help in acquain ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most o the men who visit me regularly anc they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as mucl as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.

Dr. Willard Gobbell
Family Physician
Encino, California



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this countr there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center research people, and academic people have and that's in all likelihc on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Opinion & Dialogue

He a Source of Information?

Yes, with certain reservations. e average sales representative s a great fund of information out the drug products he is re- onsible for. He is usually able to swer most questions fully and elligently. He can also supply rints of articles that contain a eat deal of information. Here, , I exercise some caution. I usu- y accept most of the statements d opinions that I find in the pers and studies which come m the larger teaching facilities. goes without saying that a physi- an should also rely on other urces for his information on armacology.

aining of Sales Representatives

Ideally, a candidate for the sition as a sales representative a pharmaceutical company ould be a graduate pharmacist o has a questioning mind. I don't ink this is possible in every case, d so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

pacity they are indeed useful; rticularly in the fact that they sseminate broadly based educa- onal material and serve not just "pushers" of their drugs.

e Other Side of the Coin

Obviously, the pharmaceuti- l companies are not producing all is material as a labor of love— ey are in the business of selling oducts for profit. In this regard e ambitious and improperly moti- ted sales representative can ert a negative influence on the acticing physician, both by pre- nting a one-sided picture of his oduct, and by encouraging the actitioner to depend too heavily drugs for his total therapy. In ese ways, the salesman has often istorted objective reality and ndermined his potential role as an ducator.

he Industry Responsibility

Since the detail man must be n information resource as well as representative of his particular harmaceutical company, he hould be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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EDITORIALS

Enlightened Policy on Smoking and Health

The New Jersey Dental Association has intelligently led the way in a recent policy statement on smoking adopted by its House of Delegates. After a series of "whereases," the "resolveds" were as follows:

Resolved, that the House of Delegates of the New Jersey Dental Association prohibit smoking at all official meetings of the Association, including, but not limited to:

1. Meetings of the House of Delegates
2. Meetings of the Board of Trustees
3. Meetings of the Reference Committees
4. Meetings of the Executive Committees
5. Meetings of the Councils and Committees
6. Scientific Meetings,

and be it further

Resolved, that the House of Delegates strongly urge all component societies to follow a similar course of action and eliminate smoking at all their official functions.

Should not The Medical Society of New Jersey and its county components follow the direction of our dental colleagues? A.K.

Weight Reduction by Edict?

Recently, a grossly obese municipal leader in a U.S. community ordered all the overweight employees of his city government to follow his example and lose weight or be fired. The psychodynamics of this situation were unclear: "misery loves company," the "crusader theory" (there is no temperance leader like a "dry" alcoholic), or possibly the uncapped latent hostility of a "happy fat man." Be that as it may, weight reduction by fear, intimidation, or threat does not work! In fact, such techniques may provoke a serious emotional disturbance, with or without actual loss of weight.

Obesity is a complex, multifactorial disorder with ethnic, familial, social, environmental, anatomic, physiological, biochemical, endocrine, and psychological influences. There may be other constituents as well. Those of us who have struggled with the problem of obesity, or who have had to treat obese patients, or who ourselves are overweight know that a simplistic dietary approach has limited success, usually with temporary weight loss, often regained in a year or less. Why is success so elusive?

Clues have come from various sources. Jules Hirsch, who has taken a close look at fat cells, has found hyperplasia (increased number) of fat cells in extreme obesity; he believes the total number of fat cells in the body is determined by the time adolescence is reached. This childhood-onset obesity seems to be harder to reverse than adult-acquired obesity, which results from overfilling of lipocytes.

Although endocrine disturbances per se do not cause obesity, there is some evidence that disturbed hormonal interrelationships may be a factor in encouraging obesity or interfering with its reversal. Insulin levels by immunoassay in obese patients are greater than normal and it is this hormone which is responsible for glucose entry into fat cells, promotion of fat storage, and formation of triglyceride by the liver. Insulin also helps to maintain fat storage by interfering with the action of lipase. Growth hormone and glucagon, which have lipolytic effects, are less active in obese individuals. The high levels of circulating insulin in obesity seem to be due to pancreatic beta cell hyperplasia, but the reasons for the latter are unclear.

Whatever the disturbance in the internal milieu, there are certain consequences. Obesity is associated with elevated serum chloresterol, triglyceride, fatty acids and certain lipoproteins, which are formed from ingested fat and carbohydrate. The low density and very low density lipoprotein particles may be incorporated in the vessel wall and lead to atherosclerosis. Although the primary role of obesity per se in the development of coronary artery disease, when other factors such as smoking, hypertension, and hyperlipidemia

are eliminated, is questionable, there are other undoubted secondary risks and problems. Gross obesity is associated with diminished cardiovascular and pulmonary function, increased musculoskeletal symptomatology, added risks of anesthesia and surgery with more postoperative complications, venous disease in the lower limbs, and skin problems.

All other aspects aside, the emotional disturbances and personality disorders which lead to or accompany gross obesity must be reckoned with. Hilde Bruch has stated that "fat people are apt to blame all their difficulties on being fat and they hope for a new lease on life after they get thin," but she has found that "achieving thinness can complicate emotional problems." Her observations include one of three outcomes for those patients who set unrealistic goals for a change in life style based on weight loss alone, without a concomitant change in emotional makeup.

The majority of such patients, whom we have all seen, will lose some weight, stop losing, give up, regain, and even overshoot the initial weight. A second end-result for some of the obese patients who suffer from the stress of "starvation" is a serious emotional breakdown, even a frank psychotic reaction. A third group succeed in becoming and remaining thin, but they maintain "all their unsolved problems, conflicts, and exaggerated expectations." They become "fat people in thin bodies;" thus, their weight reduction is only a "pseudo-cure." Does this mean that another "simplistic" approach will be better? Is ileal-bypass surgery the answer? Is psychotherapy the answer? Is wiring the mandible and maxilla together the answer? Obviously not! The first step seems to be our admission that we really don't have the answer. Having come to this conclusion, we have to be honest with the patient and inform him of what *he* can do and what the *doctor* can do. Threats, fear, and recrimination should not become a barrier between the patient and physician. Since a change in behavior is what we wish to effect, the approach of Albert Stunkard and his associates deserves consideration. The principles of behavior modification used by this group can be applied by all of us. These include patient awareness of his eating habits, daily records of food intake, restriction of eating to an undisturbed appropriate setting, certain technical changes in the mechanics of eating, and most importantly, a system of reward and reinforcement.

Failure of a patient to reduce and stay reduced is his failure, but it is also a failure of the medical profession and science. Sympathetic understanding and emotional support is in order, not an angry scowl and a finger pointing to the door. A.K.

Ethics: Individual and Social

Medical ethics are usually simplified to the point where the only criterion of ethical behavior is what is good for the patient. There is, however, a social or community aspect to medical ethics which poses some difficult dilemmas. Is this a breach of confidence? Does the duty to think only of the patient bar the duty to protect innocent contacts? Or, if your patient tells you that there is a conspiracy against him and he shows you a revolver and tells you that the next person to read his mind will be shot, do you have any duty to notify the police? Or again, do the ethics of your relationship require that you protect the patient and let society worry about itself? Every once in a while the FBI or the local police post a notice for circulation among physicians describing the medical profile of a patient and asking that the authorities be notified if he reports to the doctor for treatment. Here again, the question is raised. Is it simply a matter of the doctor doing what is best for the patient or, as in this case, is there a social morality to it all? The idea of a purely scientific approach, with disregard of the moral overtones, went out with our learning of the work done by the Nazi-dominated doctors in the late 1940's.

Nothing is simple, least of all in resolving the conflict of duties between our responsibilities to the patient and the community. H.A.D.

ORIGINAL ARTICLES

The "E" book and the disease code classification system are useful tools with internal implications in family practice. They have potential for peer review, epidemiological research, and for outreach and recall.

"E" Book and Its Implications for Family Practice*

Samuel W. Warburton, M.D.
Lambertville

Family practice record systems in the past were primarily oriented to treating patients and lots of them. High-volume family practice, by its very nature, forces each one of us independently to make thousands of small observations each year which we are really not sharing with our fellow physicians.[1] We are all "observers" in family practice, and we are working from within the system, not as some ivory tower researcher looking from the outside in. *Any* one of us could be doing research within our own practice; and, in fact, *should* be doing it. I am sure that none of you knows what he saw in the office 48 hours ago; or, in fact, can name 25 diabetics or 100 hypertensives. If you wanted to give flu vaccine to all your patients with heart disease and chronic lung disease, how would you do it?

We have available problem-oriented records to help us better define our *individual* patients and families, but do we have a mechanism to group the patients and families to better define the practice? A system does exist that will analyze our practices in an ongoing fashion that will not interfere with the volume-oriented, service-oriented family practice. Yes, Dorothy, the Land of Oz does exist. We can know total practice, our family of families, as well as we know our individual patients. Yes, the Yellow Brick Road does exist.

The System—The "E" Book—In the early 1960s the British developed a diagnostic disease code book to record doctor-patient encounter. This was developed by Dr. T. S. Eimerl, and hence the name, "E" Book. It is basically a paper and pencil device to retrieve morbidity data from an ambulatory practice.

Adopted and adapted by the Royal College of General Practitioners (RCGP) in 1963, details are simple with a minimum of writing. The "E" Book, as we are presently using it, is a looseleaf binder containing 3x5 inch sheets of paper filed in a sheafed or overlapping manner. Each small sheet contains the names of people who have one disease problem. The data entered includes the date that the patient presented with this problem, last name, first name, date of birth. Additional data may be entered to code for geographic location, referral to consultant or hospital, laboratory data, multiple codes, death, referral to public agency, etc. By sexist convention that was permissible in the 1960s, males are placed on the front side of the sheet of paper and females on the back side of the paper. Ten patients can be listed on each side. Chronic problems, such as diabetes or hypertension, are listed just once for each patient, but acute problems, such as pharyngitis, otitis media, etc., are listed as often as they occur. Because the details recorded are minimal and simplistic, all of the clerical work can be done by the office secretary.

The Code—The "E" Book contains approximately 500 slips of paper with coded numbers for various problems, diseases, and symp-

*Read before the Section on Family Practice, 208th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 12, 1974. Dr. Warburton is Assistant Director, Phillips-Barber Family Health Center of the Hunterdon Medical Center, Lambertville, New Jersey.

toms. The disease code classification is also from the Royal College of General Practitioners, modified by David Metcalf while at the University of Rochester in the early 1970's. The code is based on the ICD,[a] but was adapted for ambulatory family practice. Using the almost 4,000 numbers of the ICD,[a] it has been broken down to approximately 500 rubrics and adapted to the problem-oriented record.[2,3]

Table I

RCGP Disease Code Classification

1. Communicable Disease
2. Neoplasms
3. Allergic, Endocrine, Metabolic and Nutritional
4. Diseases of Blood and Blood-Forming Organs
5. Mental and Psychoneurotic Disorders
6. Diseases of Nervous System and Sense Organs
7. Diseases of Circulatory System
8. Diseases of Respiratory System
9. Diseases of Digestive System
10. Diseases of Genito-Urinary System
11. Deliveries and Complications of Pregnancy and the Puerperium
12. Diseases of Skin and Cellular Tissue
13. Diseases of Bones and Organs of Movement
14. Congenital Malformation
15. Certain Diseases of Early Infancy
16. Symptoms and Ill-defined Conditions
17. Accidents, Poisoning, and Violence
18. Prophylactic Procedures
19. Abnormal Investigation Results
20. Psychosocial and Family Problems
21. Family History of Specific Diseases
22. Selective Drug Index

The modified RCGP disease code classification is in use by an additional 28 family practice training programs throughout the country. Other classifications exist, including the ICDA,[b] the HICDA,[c] the Canuck Classification,[5] as well as various classifications in Australia, New Zealand, and European countries. While the system is far from perfect, it is well adapted for ambulatory care setting where problems are diagnosed at different levels of specificity than in hospitalized patients. We are accustomed to handling *un*organized problems and diseases; the classification must and does allow for this. The bulkier hospital classifications are impractical in a volume-family practice. In addition, they do not cover the problems that we see, such as family relationship problems, employment problems, legal and family history problems, as well as the non-disease we deal with in family practice involving well baby work, school-insurance-annual physicals, contraceptive work, and so on.

The coded classification is divided into 22 sections. (Table I). We are able, therefore, to code not only what we see, but to a limited extent what we do in the way of "procedures," drugs, and so on. At the end of each section there is a "catch-all" grouping that includes other symptoms, signs, and incompletely diagnosed problems within that group, as well as those not listed. Periodically, this group is "thinned" or "weeded" as problems are better defined or become more organized. A closer look at the diseases of the circulatory system shows the degree to which these problems are subdivided. (Table II). Using the sys-

Table II

Diseases of the Circulatory System

Diseases of the Heart	*RCGP*
Cor Pulmonale	209
Congestive heart failure	215
Acute myocardial infarction	211
Ischemic heart disease from all causes	212
Myocardial degeneration from other causes, including cardiomyopathy	213
Left ventricular failure (acute)	216
Rheumatic heart disease, including rheumatic fever, chorea, sequalae	210
Heart block and other disorders of rhythm	214
Other heart disease	217
Benign hypertension (with or without heart and/or renal disease)	218
Malignant hypertension (with or without organ damage)	219
Arteriosclerosis	221
Chilblains	222
Reynaud's Disease	220
Hemorrhoids	225
Peripheral arterial disease, including embolism, thrombosis, gangrene, and other diseases of arteries	223
Phlebitis and thrombophlebitis	226
Other venous embolism and thrombosis	228
Pulmonary embolism	229
Varicose veins of lower limbs	224
Other diseases of circulatory system	227
Signs and Symptoms	
Angina of effort	230
Ascites	236
Cyanosis	232
Dyspnea	235
Edema	234
Precordial pain	231
Syncope	233
Other symptoms, signs or incompletely diagnosed disease in this group	237

[a]International Classification of Diseases.

[b]International Classification of Diseases—adapted for use in the United States.

[c]Hospital Adaptation of ICDA.

tem, it is possible to code 70-80 percent of problems seen in family practice. No, your many cases of carcinoid will not have a separate number and neither will your many cases of systemic lupus erythematosis, but that is the way it should be!

How does this system work?—When a patient enters the office and is taken back into the examining room, the nurse writes the date, the patient's last name, first name, birth date, marital status, and sex on a worksheet. Later that same day the doctor fills in the titles of the various problems and the numbers for those problems on that worksheet. With frequent use, the 100 most common numbers rapidly roll off your tongue: Hypertension—218; URI without fever—240; Schizophrenia—125; Well baby exam—511B; and so on. The secretary in our practice then uses the worksheet to fill out the actual "E" Book itself. We use a separate "E" Book for each doctor within our practice, and find as other practices have found that two to three hours a day is sufficient time to record all the problems for six doctors working in the practice. We then strip the "E" Book every six months and analyze the accumulated data in various fashions.

What, then, does the system cost?—Most of us are purchasing our systems from the Rochester Family Medicine Program where they can be purchased for $60 a set. The system has the beauty of being adaptable to computer use, but in its present form as we are using it, it is readily accessible, it is concrete, it is cheap, and with great speed we can pull lists of patients with various problems and then review their problems, send them new educational material, and so on. The present system is portable and self-contained. At least half of our residents will be taking their actual "E" Book with them into their National Health Corps Practice, Navy, Air Force, or private solo or group family practice. This experience has been replicated by other residencies using the "E" Books.

Uses in the PBFHC[f]—One of the simplest things that we use the "E" Book for is to profile the office practice of our various family practice residents. We can compare the experience of our residents with each other as well as nationally known family practice experiences. (Table III).[5,6,7,8,9] We are able to define blind spots in the resident's problem definition and management, such as obesity, male depression, family living problems, and so on. Conversely, we can spot *over*-utilized diagnoses and problems for which the resident may not have a clear definition. We can also spot untreated problems in resident profiles and so for teaching purposes, direct patients with known problems accordingly. Additionally, the "E" Book gives the resident a log or journal of his three years' experience in the model family practice unit, which he could then use to define his privileges in any hospital in the country.

Table III.

Rates of Illness in General Practice (per 1,000 patient visits)

	NCGP[d] (1953-4)	NDTI[e] (1965)	Mass AAFP (1966-7)	Res. "A" (1973)
1. Communicable Dis.	37	21	24	50
2. Neoplasms	15	12	28	7
3. Allergic, etc.	44	87	57	60
4. Blood	16	14	14	7
5. Mental Illness	32	108	40	61
6. Sense Organs	41	57	52	72
7. Circulatory	83	89	101	49
8. Respiratory	182	118	105	140
9. Digestive	56	76	60	48
10. Genito-Urinary	79	75	38	58
11. Pregnancy	31	3	13	35
12-13 Skin and Bones	71	121	76	92
14-15 Congenital and Perinatal	4	2	3	8
16. Symptoms	44	45	33	10
17. Accidents	88	60	102	80
18. Nonsickness	161	112	249	191
19. Abnormal Findings	—	—	—	3
20. Social	—	—	—	24

There are numerous uses for peer review and self-audit. In our office, we use the "E" Book once a month to pull all the charts of patients with a specific problem, such as hypertension, urinary tract infection, diabetes, etc.

[d]North Carolina General Practitioner Survey of 1954.

[e]National Disease and Therapeutic Index Study of 1965.

[f]Phillips-Barber Family Health Center.

TABLE IV

Problems Other Than Specific Diagnostic/Symptomatic

Whole Family Problems	
Economic problems	700
Housing problems	701
Medical care problems	702
Educational problems	703
Family relationship problems	704
marital conflict	704A
parent/child conflict	704B
in-law problems	704C
other family relationship problems	704D
Legal problems	705
Other high risk family situations	706
Alcoholism in parent or child	727
Drug abuse in parent or child	728
Individual Problems	
Pregnancy and birth out of wedlock, in parent and child	707
Social isolation	708
Occupational maladjustment	709
Dependency	710
Chronic physical disability	711
Other high risk individual	712
Employment	
Out of work acute	713
Out of work chronic	714
Medical absenteeism	715
Unemployment because of illness	716
Other employment problems	717
Legal	
Imprisonment	718
Prosecution or impending litigation	719
Divorce proceedings	721
Other legal problems	730
Other social problems, family and individual	722
Perceived High Risk Situations	
High risk infant	723
High risk pregnancy	724
High risk accident in household	725
High risk physical violence in household	726
Adopted child	731
Foster child	732
Other social/personal problems	729

We then review our handling of the particular problem with respect to parameters of diagnosis, treatment, patient education, follow-up, age-sex distribution, etc. After this is completed, we call in a specialist and, during a two-hour consultation, compare what we are doing with what the specialist feels we ought to be doing. In this way, we hope to continually upgrade our office management of chronic disease. This method of peer review is already in use in numerous private practices, most notably Bjorn and Cross, of problem-oriented record fame. In private practice, the "E" Book would have several uses in postgraduate education. The distribution of problems might prove enlightening to the physician. He could, therefore, choose a postgraduate course on the basis of the most difficult common problems that he sees, or within a problem area, such as diabetes, he could review cases or actually take along specific problem charts with him to a meeting or course and get curbside consultations for these particular patients.

The "E" Book has uses in office management, especially in terms of personnel. Analysis of the "E" Book figures might show that the practice would benefit from a change of personnel, for instance, the addition of a pediatric nurse practitioner, or a social worker, such as we recently added. In the case of the social worker, the "E" Book can then supply her with initial case load using the 700 Series (Table IV) which deals with various social problems of finance, education, relationship problems, etc. The "E" Book might also point out the need for more specialized equipment, e.g.: the capacity for prothrombin times, blood sugar analysis or treadmill testing in the office. Is your partner really working faster, or just handling simpler problems? This is another question that might be answered by the "E" Book.

Outreach is another use to which the "E" Book has been placed. Patient education classes for those with heart disease or chronic pulmonary disease are more meaningful if patients are individually notified. Large groups of patients with a particular problem can be notified via phone or mail of new treatment or changes in treatment, e.g.: the Orinase® "controversy." We use the "E" Book each fall to define these patients who are to be reminded to get injections of flu vaccine.

Finally, combined studies and research are possible through the use of a disease index and "E" Book. Figures are available, from this simple method, on incidence and prevalence of problems and disease in a particular area of practice. There is, of course, computer capability, but the "guts" of the system remain simple and are tried and tested over the past fifteen years. There are a number of combined projects in progress at this very mo-

ment in various parts of the country and around the world. This will ultimately allow for area-wide health planning and tracking of area-specific health problems.

In summary the "E" Book and the disease code classification system are designed specifically for family practice. The system is cheap, quick, and easy; it rapidly defines the sphere of health and disease for your particular practice. The system and the code profile your practice and emphasize disease areas you see a lot; they highlight your particular blind spots. They allow personnel changes on closer review of the data. Peer review is possible internally by you and your partners or group looking at the data; externally it is done by bringing in a consultant, or by taking your problem, as defined from the "E" Book, to a specialized meeting or course. The system has the distinct capability for outreach and recall in terms of drug problems and patient education. The family doctor is certainly put in a more active role, if he so wishes. Finally, the system has capabilities for research involving morbidity and epidemiology within family practice. The "E" Book and the disease code classification, therefore, are a few of the various "bricks" in the Yellow Brick Road that will carry Dorothy, our friendly family physician, to the Land of Oz, the Utopia where we all know everything about all that we do.

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P.O. Box 37

Status of Mechanical Assistance for the Failing Ventricle

Despite the enormous effort in the field of mechanical assistance, there is as yet no real proof that either invasive or noninvasive methods currently being used significantly reduce inhospital mortality following myocardial infarction. These methods, however, do permit very ill patients to undergo invasive investigations to determine the need for, and feasibility of, direct coronary arterial surgery or myocardial excision or repair which otherwise could not be done.

An equally important use for mechanical support is in the very ill patient going forward for open-heart valvar surgery. During the prepump and immediate postpump phases, and again in the early postoperative period, mechanical circulatory support can have a dramatically beneficial effect and permit subsequent recovery of a patient who otherwise might well succumb.

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Aberrant pancreatic tissue may cause pain, due to ductal obstruction and abscess formation. Local excision, with or without pyloroplasty, or a limited gastric resection is curative.

Pancreatic Heterotopia with Abscess Formation in the Stomach

Adam R. Wychulis, M.D., Albert Sasso, M.D., and Raymond Carnes, M.D./Newark*

Aberrant pancreatic tissue has been found in the stomach, duodenum, jejunum, ileum, Meckel's diverticulum, gallbladder, cystic duct, liver, spleen, mesentery, omentum, and umbilicus. In a collective review of cases of pancreatic heterotopia recorded in the literature, Barbosa, *et al.*,[2] found that 25.5 per cent were located in the stomach while the most common site was the duodenum with a 27.7 per cent incidence.

When heterotopic pancreatic tissue in the stomach is responsible for symptoms, it usually does so by interfering with peristaltic activity, by prolapse through the pylorus, or by ulceration of the overlying gastric mucosa. We have recently encountered an unusual case in which abscess formation probably followed ductal obstruction in heterotopic pancreatic tissue of the gastric antrum.

Case Report

A 32-year-old housewife was admitted to Saint Michael's Medical Center on June 21, 1972, because of epigastric pain and vomiting. About 20 months earlier, she began to experience occasional bouts of vomiting which seemed to occur just prior to menstrual periods. The patient was hospitalized elsewhere eight months prior to admission with epigastric pain radiating to the back and vomiting of three days' duration. A gastric ulcer was reported on x-rays of the upper gastrointestinal tract at that time, and she was treated with antacids and a bland diet with relief of symptoms. Four months later, a persistent ulcer and a nodular lesion in the greater curvature of the antrum were noted on repeat x-rays. No abnormalities were visualized on gastroscopic examination at that time. The patient remained symptom-free until two weeks prior to admission when she began to vomit after every meal. Also, she complained of intermittent epigastric pain which radiated to the back and was unrelated to food intake or to vomiting.

Figure 1-A—Upper gastrointestinal series. Mass present along greater curvature of antrum proximal to pylorus.

Physical examination revealed an obese female in no apparent acute distress, with no abnormalities, except for tenderness in the epigastrium on palpation.

Hemoglobin was 12.6 gm. per 100 ml., white blood count was 5,100 cells per cu. mm., with a normal differential count. Urinalysis was negative and the

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Figure 1-B—Upper gastrointestinal series. Linear extension of barium into the center of the lesion.

urinary amylase was within normal limits. Gastroscopic examination showed an elevated area in the antrum thought to be compatible with a submucosal tumor.

Cholecystograms were normal but x-rays of the gastrointestinal tract showed a mass along the greater curvature aspect of the antrum approximately one centimeter proximal to the pylorus (Figure 1-A). A 6 mm. linear extension of barium into the center of the lesion was observed (Figure 1-B).

Diagnosis at the time of operation on June 26, 1972, was pancreatic heterotopia of the stomach. A palpable lesion on the posterior inferior wall of the antrum adjacent to the pylorus was excised together with some adjacent tissue; and frozen section examination revealed pancreatic tissue. The opening in the stomach was then continued across the pylorus and into the first portion of the duodenum. A Finney-type pyloroplasty was performed to provide a good gastric outlet.

Figure 2—Mucosal aspect of resected gastric antral tissue with probe in heterotopic pancreatic duct.

Gross examination of the specimen disclosed two dimpled areas which could be probed to a depth of approximately 1 cm. in an otherwise intact mucosa (Figure 2). On section, the muscularis was found to be moderately thickened and pinkish-grey in color.

There was a cystic area in the submucosa which measured 2 cm. in greatest diameter and contained yellowish, mucopurulent material. The overlying serosa was unremarkable. Microscopically, the tumor was composed of acinar pancreatic tissue with ducts located in the submucosa, hypertrophied muscularis, and in the subserosal tissue (Figure 3). There was also an abscess, the wall of which was lined with acutely and chronically inflammed granulation tissue with scattered foreign-body-type giant cells. Cultures of the abscess were negative.

The patient was discharged from the hospital ten days postoperatively after an uneventful course. When last seen in July, 1973, she was asymptomatic.

Comment

The largest series of heterotopic pancreatic tissue involving the stomach was reported by Martinez, *et al.*,[4] from the Mayo Clinic. They found a total of 51 surgical cases over a 47 year period but only 28 were considered clinically significant. A review of the pancreatic anomalies observed at the Lahey Clinic[8] disclosed 22 ectopic pancreatic masses involving the stomach, only 10 of which accounted solely for the clinical symptoms that led to operation.

Heterotopic pancreatic tissue is found in all age groups but it is most commonly encountered in the fourth and fifth decades of life. There is a slightly greater incidence in male patients.[4] When these lesions are symptomatic, they usually mimic peptic ulcer or biliary tract disease. History and physical examination offer nothing diagnostic of this particular entity.[6] Rarely, the first indication of the presence of this lesion may be acute gastric hemorrhage.[7] Although epigastric discomfort and tenderness are frequent findings in symptomatic patients, there was no mention of pain radiating through to the back among previously reported cases.

If pancreatic heterotopia is to be diagnosed preoperatively, it must be recognized by the radiologist and/or the gastroscopist. Nelson and Scott[5] were able to visualize four of five

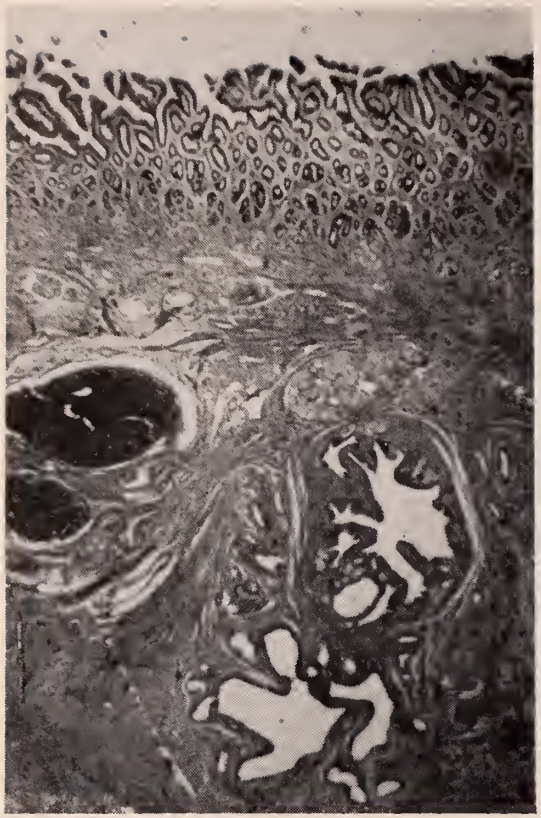

Figure 3-A—Pancreatic ducts and two ovoid lobules of darkly stained acini in thickened wall of stomach. Gastric mucosa lines and upper surface (hematoxylin and eosin, x25).

Figure 3-B—Submucosal abscess inferiorly and pancreatic ducts superiorly (hematoxylin and eosin, x25).

cases of heterotopic pancreatic tissue in the stomach by gastroscopy. The roentgenologic findings are most frequently consistent with those of a polypoid tumor. When barium-filled excretory ducts contained within the boundaries of a small filling defect are demonstrated, a diagnosis of heterotopic pancreatic tissue is justified.[4]

Aberrant pancreatic tissue is most often found in the distal third of the stomach and can be in the submucosa, the muscular layers, or the subserosa.[3] Although this anomaly is antenatal in origin[2], it is rarely symptomatic in children. As a polypoid lesion, it may cause intussusception with resultant obstructive symptoms. Ulceration of the overlying mucosa occurs in other cases and symptoms are indistinguishable from peptic ulcer disease[1]. Although all diseases which affect the pancreas proper may occur in aberrant pancreatic tissue, most such pathologic changes have been encountered in areas of the gastrointestinal tract other than the stomach. Abscess formation in our case was most likely a result of ductal obstruction, while the symptoms were probably due to interference with persistaltic activity by the inflammatory reaction in the muscle wall.

When the nature of the lesion is recognized at surgery, local excision is adequate. Because the heterotopic mass is often located in the prepyloric region, the surgeon may have to utilize an additional procedure such as pyloroplasty to ensure a good gastric outlet. Occasionally, a limited gastric resection may be necessary when there is a large amount of induration and the true nature of the lesion is not recognized.

Summary

A case of pancreatic heterotopia of the stomach treated successfully by local excision and pyloroplasty is reported. A unique aspect of

this case was the presence of an associated abscess which was probably due to ductal obstruction within the aberrant tissue.

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306 High Street

Diabetes Tapes by Phone

Information about diabetes mellitus is now available to all diabetics and their family members living in New Jersey.

Residents of northern New Jersey (Bergen, Essex, Hudson, Hunterdon, Morris, Passaic, Somerset, Sussex, Union, and Warren Counties) should call (201) 375-2527, Monday through Friday from 9 a.m. to 11 p.m.

Those individuals residing in central and southern New Jersey (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Middlesex, Monmouth, Ocean, and Salem Counties) should place a collect call to (609) 586-4833, Monday through Friday from 7 a.m. to 9 p.m. and on Saturday from 7 a.m. to 5 p.m.

This free service is sponsored by the New Jersey State Department of Health, the New Jersey Diabetes Association, and the New Jersey Regional Medical Program, Inc., in conjunction with several county component medical societies.

A series of ten tapes may be heard by placing a *collect* call to one of two centers. Tapes are available both in English and Spanish: ask for the following tape numbers checked by your physician (pida los numeros siguentes indicados por el medico suyo).

- ☐ 1. What is Diabetes? (7 minutes)
- ☐ 2. Management of Diabetes (10 minutes)
- ☐ 3. Normal Diet (9 minutes)
- ☐ 4. Insulin (9½ minutes)
- ☐ 5. The Child with Diabetes (9 minutes)
- ☐ 6. Diet for the Child with Diabetes (9 minutes)
- ☐ 7. Urine Testing (8 minutes)
- ☐ 8. Diabetic Foot Care (7 minutes)
- ☐ 9. Special Diets (12 minutes)
- ☐ 10. The Acute Complications: Insulin Reaction and Diabetic Coma (11 minutes)

- ☐ 1. ¿ Que es la Diabetes? (6 minutos)
- ☐ 2. Control de la Diabetes (9 minutos)
- ☐ 3. La Dieta Normal (8 minutos)
- ☐ 4. La Insulina (9 minutos)
- ☐ 5. El Ninõ Diabetico (9 minutos)
- ☐ 6. La Dieta del Ninõ Diabetico (7 minutos)
- ☐ 7. Examen de la Orina (7 minutos)
- ☐ 8. Cuidado de los Pies Diabeticos (6 minutos)
- ☐ 9. Las Dietas Especiales (10 minutos)
- ☐ 10. Complicaciones Agudas: Reacción a la Insulina y Coma Diabetico (9 minutos)

Prescription blanks which contain this information are available from the State Department of Health.

The management of the myasthenic patient should begin with carefully titrated anticholinesterase therapy. As soon as symptoms deteriorate or spread, transcervical thymectomy should be performed without waiting for crises to develop. Carefully selected patients, particularly those who have not responded to thymectomy, may require multiple courses of ACTH to maintain a functional state.

Current Concepts in Myasthenia Gravis*

Peter Kornfeld, M.D. and Gabriel Genkins, M.D./Englewood

Introduction

Myasthenia Gravis (MG) is a neuromuscular disease characterized by various degrees of striated muscle weakness, aggravated by exercise and improved by rest. Spontaneous exacerbations and remissions occur frequently. Faulty neuromuscular transmission is generally cited as the physiologic cause, but it remains to be proved whether the abnormal phenomena at the motor end plate are primary etiologic factors or merely reflect pathology higher up in the nervous system, or elsewhere in the body.[1] It is the only human disease in which the thymus gland is prominently involved and therefore affords a vehicle for study of thymic function as well as of neuromuscular transmission. Myasthenia gravis has no respect for age or sex and may occur from birth to the tenth decade. While five percent of our patient population has been interrelated, genetic familial studies have been incomplete and no definite statement regarding a genetic pattern can be made.[2] The generally quoted incidence of myasthenia gravis of 1 to 20,000 population is probably an underestimate as many subclinical, undetected cases exist.

Over-all, females with myasthenia gravis outnumber males by 3 to 2. The peak incidence of the disease among females occurs during the reproductive phase of life with a sex ratio of 3-4 to 1. Peak incidence among males is between ages of 50-70 with sex ratio of 1 to 1.[2] Progress in the treatment of MG over the past twenty years has markedly cut the mortality and improved the prognosis of these patients. Our observations are based on clinical experience with over 1,400 myasthenic patients observed during the past 22 years.

Pathophysiology

A defect in the neuromuscular junction accounts for the weakness of voluntary muscles in myasthenia gravis. The presynaptic nerve terminal is the site of acetylcholine (ACH) formation which is then stored in vesicles. As a result of electric depolarization of the axon, this vesicle-stored ACH is released and must transverse a 200° A gap to reach the receptor site in the post-synaptic membrane and generates an end plate potential which enables the muscle to contract. However, not all of the generated ACH is available for release; a portion exists in inactive form. The belief that decreased ACH production (smaller quanta) is responsible for the myasthenia defect has recently been challenged. Rosenberg believes that atrophied nerve terminals and a 40 per cent reduction in surface area of the presynapse are the primary cause for decreased acetylcholine contents rather than an impaired rate of synthesis of ACH.[3] It has also been demonstrated that the number of trans-

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mitter receptor sites at the myoneural junction is significantly diminished in myasthenia gravis.[4] Other possibilities such as production of false transmitters, excess anticholinesterase activity or inactivation of ACH in end plate cleft have not yet been excluded. The possible existence of antibodies to one or more components of the neuromuscular junction which might interfere with the uptake or release of ACH or block receptor sites in the post synapse have been the subject of recent intense investigations.

Associated Diseases

The following illnesses, many of which have been classified as "auto-immune," have a statistically increased incidence in myasthenia gravis: (1) thyroid disease—particularly hyperthyroid states, (2) diabetes mellitus, (3) rheumatoid arthritis, (4) hemolytic anemia, (5) chronic lymphatic leukemia, (6) pemphigus, (7) polymyositis, and (8) malignancies (particularly carcinoma of the breast).[2]

Symptoms

Onset of MG may or may not coincide with other diseases, trauma, or emotional upsets. Initially, muscle weakness may only be noted after prolonged activity or toward the end of the day. The patient may volunteer information that a brief rest reinvigorates her and she usually feels best after a night's rest. The frequency of the most common symptoms and signs is outlined in Table 1.[2] Bright light, sunshine, menses, excess alcohol, or recurrent illnesses may all aggravate myasthenic symptoms. While the patient may complain of weakness in only one muscle group, thorough examination will frequently reveal involvement of other muscles as well. As a matter of fact, any patient with only involvement of a single muscle group (particularly isolated ptosis) should be routinely subjected to electromyography (EMG) of the extremities. If EMG is negative, a regional curare test should be performed.[5] Ptosis and double vision, the "Mona Lisa smile" due to facial weakness, inability to close the mouth due to jaw muscle involvement, difficulty in chewing, inability to hold up the head, nasal regurgitation of fluids due to dysphagia, and speech characterized by a nasal twang are frequently observed. Respiratory distress depends on whether the diaphragm and/or accessory respiratory muscles are involved. Involvement of extremities may or may not be symmetrical. Muscle atrophy ("myopathic" EMG pattern) early after the onset of MG may be observed in a small percentage of patients, but fasciculations are not seen in untreated patients. Similarly there are no reflex or sensory changes, save for pain secondary to muscle weakness or imbalance. Occasionally, nystagmus can be observed in connection with extraocular muscle deficits. The most critical of all symptoms is that of "crisis." "Myasthenic crisis" means severe generalized weakness associated with respiratory insufficiency secondary to absence of or inadequate drug therapy. "Cholinergic crisis" may present with the identical clinical picture, but it is due to an overdosage of anticholinesterase medication. In both instances hypoventilation, accumulation of secretions, aspiration and secondary infections may lead to death unless the patient is treated correctly and promptly.

Table I
Frequency of Most Common Symptoms and Signs

Symptoms and Signs	Percentage At Onset	Percentage Current Status
Ocular		
Diplopia	43	73
Ptosis-Bilateral	27	59
Ptosis-Unilateral	40	25
Bulbar		
Dysarthia	27	61
Dysphagia	23	63
Chewing Weakness	16	52
Dyspnea	6.5	33
Skeletal		
Generalized Weakness	15	45
Facial Weakness	8.5	38
Neck Weakness	9	40
Trunk Weakness	3.5	14.5
All Extremities	10	44
One or Two Extremities	25	45
Atrophy	—	6.3
Subjective Sensory Symptoms	—	9

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Clinical Classification

Table 2 summarizes the clinically dynamic classification which allows for prognosis or planning a therapeutic approach.[6]

Table 2

Clinical Classification of Myasthenia Gravis

Group	Clinical Classification	Clinical Characteristics	Prognosis
Pediatric	a. Neonatal	Mother must have myasthenia gravis; incidence is 1 in 5-6 births; if properly treated the disease disappears by 6-8 weeks of age, never to return.	Excellent
	b. Juvenile	Mother is not affected; MG can occur at any time between birth and puberty; usually present for life; drug responsive.	Good
Adult	I	Ocular MG; if no spread of symptoms occurs to other muscles within 3 years, the MG will usually remain stable.	Excellent to good
	IIA	Mild generalized MG with slow progression; no crises; drug responsive.	Good
	IIB	Moderate generalized MG; severe skeletal and bulbar involvement, but no crises; drug response is less satisfactory.	Good to fair
	III	Acute fulminating MG; rapid progression of severe symptoms with respiratory crisis and poor drug response; high incidence of thymoma; high mortality.	Poor
	IV	Late severe MG; same as III, but takes 2 years to progress from Classes I or II; crises; high mortality.	Poor

Table 3 summarizes the distribution of patients with myasthenia gravis by clinical classification.

Table 3

Distribution of Myasthenic Patients by Clinical Classification[2]

	Number of Patients	Percentage
Pediatric		
Transient Neonatal	20	1
Juvenile	111	9
Adult		
Group I	246	20
Group IIA	357	30
Group IIB	249	20
Group III	136	11
Group IV	111	9
Total	1230	100

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Diagnosis

A good history is of paramount importance and should arouse suspicion if weakness is brought out by activity and relieved by rest. Myasthenia per se is usually unrelenting and may be differentiated from thyroid and steroid myopathy and from neurasthenia by the history. Complete physical and neurological examinations should be carried out on the rested patient in a non-medicated state. The patient can then be challenged with exercise, bright light, and the "red glass test."† Pharyngeal muscle function can be tested by means of a barium swallow. Respiratory efficiency will be reflected in easily measured tidal volume, vital capacity, and maximum breathing capacity. In addition to routine laboratory and thyroid function tests, postero-anterior and slightly overexposed lateral x-ray views of the chest are mandatory to ascertain whether the retrosternal space is clear or contains an enlarged thymus or thymoma. If x-rays are inconclusive or the patient has a relentless downhill course, tomograms of lateral mediastinum are of decisive importance.

The single most valuable clinical test is the edrophonium (Tensilon®) test which is carried out after initial strength is determined by dynamometer or ergograph testing.[7] The patient is then allowed to rest for five minutes. A placebo injection (20 mg nicotinic acid) is given and the patient is re-examined. After another five minutes' rest, the edrophonium test is performed. One half cc (5 mg) of edrophonium is drawn into a syringe, but only 0.2 cc is injected. After 60-90 seconds the affect-

†Optometric procedure for reinforcing subclinically present extraocular muscle weakness to establish the presence or absence of diplopia.

ed muscles are retested. If no significant response is obtained, the remaining 0.3 cc are injected intravenously and the patient is retested one minute later. Of all myasthenic patients in need of medication, 99 per cent will respond to such a dose of edrophonium. We hesitate to use larger doses, particularly in elderly or cardiac patients, because of the possibility of inducing heart block. If the edrophonium test remains negative, but the examiner has obtained a suspicious history, the patient should undergo electromyographic testing with 3-20/sec. stimulation. If this does not elicit a decline in muscle strength, a "regional curare test" should be performed.

Medical Treatment

1. *Anticholinesterase Drugs*—The drug of choice is pyridostigmine bromide (Mestinon®), an analogue of neostigmine (Prostigmin®), a cholinesterase inhibitor. Pyridostigmine is more effective, faster acting, and has less muscarinic side effects than neostigmine. It is available in quarter scored 60 mg tablets, syrup (60 mg/5 ml) and 180 mg Timespan® capsules. For those patients who are allergic to bromide, a pyridostigmine chloride tablet of 50 mg is available. Pyridostigmine is also available in injectable form (Mestinon® and Reguol®) for intramuscular and intravenous injection, but its use is largely limited to hospitalized patients. Edrophonium is not suitable for therapy, because of its brief duration of action, but it is excellent for diagnostic purposes. Other drugs, such as ambenonium (Mytelase®), have little advantage over pyridostigmine and possess a smaller therapeutic index. It is extremely unlikely that a patient unresponsive to pyridostigmine will obtain relief from ambenonium or vice versa. Pyridostigmine is poorly absorbed from the gut, thus explaining the 30 to 1, oral to parenteral dose ratio. The injectable equivalent of one 60 mg tablet is 2 mg. A 15 mg neostigmine tablet is pharmacologically equivalent to a 60 mg tablet of pyridostogmine. Side effects consist of exacerbation, salivation, abdominal cramps, diarrhea, muscle fasciculations, and can be readily relieved by atropine. Atropine, however, should not be administered routinely with each dose of anticholinesterase as such action might mask approaching toxic signs and symptoms. Once the diagnosis of MG has been established and symptoms are sufficient to warrant drug therapy, patients should be advised that the aim is to correct symptoms less than completely. Increasing the drug dose above maximum response in vain hope of improving physical strength will only result in progressive weakness and cholinergic crisis. The patient is usually started on an initial dose of 15 to 30 mg pyridostigmine every four hours. Dose adjustment will depend on the patient's clinical behavior as well as edrophonium testing. Thus, administration of 2 mg edrophonium intravenously one hour after pyridostigmine ingestion (time of peak blood levels) will ascertain if the patient is under or overdosed. Doses should be raised in 15 mg (¼ tablet) increments only, and gradually. If the patient reports increased weakness one hour after medication and feels worse than before, the dose must obviously be cut back. If, on the other hand, the patient is improved, better regulation has been achieved. History will usually be adequate to determine if the interval between doses should be reduced. In other instances the edrophonium test may also be employed to determine the correct interval between doses. It should be pointed out that testing the drug adjustment should not be done too frequently; and the patient should be allowed to reach equilibrium over 2 to 3 days before changing dosage. Such equilibrium is usually a dynamic change rather than a static point and the patient should be educated in self-drug management within limits. Pyridostigmine Timespan® tablets (180 mg) should be used only for night time coverage because of its more sustained therapeutic effect, allowing patients to get a night's sleep. However, dosage at bedtime should be reduced by ½ to 1 tablet (as compared to 60 mg tablets) because of diminished muscle activity at night and the unpredictable release and absorption of pyridostigmine from the Timespan.® Such delayed absorption may also influence the early morning doses, which may have to be reduced proportionally.

"Brittle" patients are those that fluctuate between myasthenic and cholinergic crisis. It

may be advisable to hospitalize such patients for better regulation and to perform tracheostomy if respiratory adequacy is in doubt and patients cannot adequately raise pulmonary secretions. In case of dysphagia a nasogastric tube can be passed through which the patient can be medicated and fed. If the treating physician suspects cholinergic crisis, all anticholinesterase medication should be withheld for at least 48 to 72 hours and the patient given respiratory assistance if necessary.[8]

2. *Adjuvant Drugs*—Adjuvant drugs, such as ephedrine, calcium, theophylline, potassium, or spironolactone may be added after optimal results have been obtained with anticholinesterases. In most instances their effect is minimal at best.

3. *ACTH*—ACTH therapy is limited to those patients in Classes III and IV and must always be carried out in an intensive care unit within the hospital. Details of this therapeutic regime have been published elsewhere.[9] Ninety percent of such courses of ACTH are followed by improvement or remission of various durations. This modality has allowed many patients to return to a productive life. Recently, we have combined the administration of 10 cc of gamma globulin intramuscularly every three weeks with such ACTH courses and achieved synergistic improvement.[10] In many instances, protracted clinical improvement may be secured by administering periodic ACTH and gamma globulin booster injections to ambulatory patients. Such injection may be followed by 24 to 48 hours of transient weakness, so the ACTH and gamma globulin should not be administered simultaneously.

Our experience with alternate-day, massive prednisone therapy has been very disappointing and generally ineffective in Class II and IV patients.[10] Furthermore, prolonged prednisone therapy produced more numerous and severe complications than seen in ACTH-treated patients, including osteoporosis, steroid myopathy, gastrointestinal bleeding, and psychoses. In view of the potential hazards of this treatment modality, we do not advise its use in patients with pure ocular myasthenia gravis which is unresponsive to anticholinesterases. The mechanism of action of steroids in MG is not clear but it is probably, at least in part, immunosuppressive. Use of other immunosuppressive drugs or antilymphocyte or antithymocyte globulin is still controversial and highly experimental.

4. *Contraindicated drugs:*

a. Quinine, quinidine, procainamide all interfere with neuromuscular conduction. (The use of tonic water in cocktails is contraindicated.) Digitalis, lidocaine or diphenylhydantoin are permitted for treatment of cardiac arrhythmias.

b. Ether and large doses of barbiturates increase the neuromuscular blocking action of d-tubocurarine.

c. Chloropromazine and muscle relaxants.

d. Ganglionic blocking agents and potassium depleting diuretics.

e. Neomycin and dihydrostreptomycin are absolutely contraindicated. Increased weakness has been reported after the use of streptomycin, viomycin, kanamycin, colistin, polymycin A and B, and sulfonamides. However, most of these drugs had been administered in fairly large doses following general anesthesia; and the resultant weakness probably represented a summation effect.

Thymus and Myasthenia Gravis

Myasthenia gravis is the only disease in which the thymus is held to be actively involved. About 70 percent of myasthenia patients have demonstrable abnormalities of the thymus. The presence of germinal centers within the gland has been listed as evidence for the presence of an auto-immune process.[1] Of patients with myasthenia gravis, 10 to 15 percent have thymomas and their MG carries a bad prognosis. Although thymomas do not metastasize outside the thorax, death will come within two years unless thymectomy is performed. Our experience, and that of others, has been that thymectomy arrests the progress of disease and decreases mortality.[6,11,12]

FIGURE 1

NATURAL COURSE OF MYASTHENIA GRAVIS

PATHOLOGY:	Normal	Start of MG (Cause?)	↓ ACH Production		Autoimmune Changes ? thymitis ? Ab fixation to ACH receptors	Irreversible Changes (Atrophy of motor end plates)
CLINICAL CLASSIFICATION:	Normal	X	I	IIA IIB	III IV	Burnt Out MG
					Brittle MG (Crises, thymoma)	
RESPONSE TO:						Resistant to all therapy
Anticholinesterase (0-4+)	--		4+	3+ 2+	1+ - 0	0
Steroids			Not indicated	4 - 3+	4+ - 0	0
Thymectomy				3 - 4+ Ideal time for thymectomy	2+ - 0	0

Since the advent of the transcervical approach, major postoperative mortality is essentially absent and the patient frequently leaves the hospital within a week.[12] Long-term results, in terms of remission, are equal to those obtained with the thoracotomy approach. As large numbers of thymectomies have now been done earlier in the course of the disease, there has been a significant decrease in the percentage of cases that progress to Classes III and IV. Early thymectomy has also resulted in marked reduction of the often-quoted 15 percent incidence of thymoma among MG patients.

Two types of clinical post-thymectomy remissions are observed: (a) rapid and (b) delayed. The latter may reflect the time required for depletion of lymphocytes (T cells) which are sensitized to unknown components of the neuromuscular junction.[12] Preliminary studies in our laboratory of the sera of many myasthenic patients confirm the presence of circulating antibodies, which fix to the ACH receptor sites at rat muscle end plates.[13] This agrees with Patrick and Lindstrom who were able to produce myasthenia gravis in rabbits by injecting ACH receptor protein coupled with Freund's adjuvant.[14]

Finally, there is a group of patients who do not respond to any form of therapy; here we suspect that irreversible damage has taken place at the end plate. Another cause for failure to respond to thymectomy may be residual or ectopic thymic tissue overlooked at time of surgery.

Recent work has indicated a tenfold higher incidence of breast carcinoma in women with myasthenia gravis prior to thymectomy.[15] A similar increase in leukemia and a five-fold increase in the attack rate of other extrathymic neoplasms has been noted in MG patients.[15] Following thymectomy this incidence returns to the levels prevalent in an age-matched general population. The implications of this study are monumental, but require further elucidation.

Conclusion

We postulate myasthenia gravis to be a single disease entity rather than a syndrome, which may or may not progress through several stages. This concept is outlined in Figure 1. Early thymectomy is indicated to prevent the disease from progressing to the auto-immune and "burnt-out" stages.

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Health Effects on Environmental Pollution*

In a current government publication,* the foreword states: "For a long time the American people seemed willing to pay any price for progress. Now they refuse to accept an environment that menaces their health and lowers their enjoyment of life. They are embracing a new environmental consciousness, a broader vision of reality, a more profound sense of their place in nature."

The same publication points up the dangers to health of increasing man-made radiation (medical-dental x-rays and isotopes, fallout from nuclear weapons testing, faulty color television sets, uranium mines, mills and fabrication plants, nuclear-power generating and fuel-reprocessing installations, and various electronic devices), which is superimposed on the radiation we all receive from natural sources. Even certain building materials (conasauga shale, blocks made from phosphate rock and granite) seep radioactive gases or gamma radiation into the ambient air. Although man's exposure to radiation has been quite low, very little is known about the long-term effects of repeated or continuous exposure to low levels of radiation. The major hazard is genetic, for it is generally accepted that even small amounts of radiation can cause damage to genetic cells and an unpredictable number of undesirable mutations, which can be cumulative.

**Health Effects of Environmental Pollution.* U.S. Environmental Protection Agency. Washington, D.C., May 1973.

Impetigo today is primarily due to Group A streptococcal disease, which spreads from normal skin and is best treated by systemic antibiotics.

New Findings in Impetigo

T. Scillia, M. Skehan, and Leon G. Smith, M.D./Newark*

Etiology and Spread

Impetigo is a common dermatological infection in children five to seven years of age. This disease occurs in neonates and adults as well. There are many new developments and questions about impetigo that should be shared with the practicing physician. Impetigo has been associated with myths, fears, and misunderstandings that need correcting. It is for this reason that we have reviewed the new studies on spread of the impetigo, the development of acute glomerulonephritis, and the latest on topical versus systemic antibiotics in the treatment of impetigo.

Group A beta hemolytic streptococci and staphylococci are the predominant bacterial genera recovered from nonbullous impetiginous lesions; the former being the primary etiologic agent and the latter in the subsidiary role as secondary invader.[3] This is in contrast to studies of years ago where S. aureus was thought to be the only pathogen. The site sequence of spread of staphylococci is from nose to normal skin to skin lesions. In contrast to this, the site sequence of Group A streptoccocci in relation to the development of impetigo is from normal skin to lesions (mean interval of 10 days) and finally to nose and throat (mean intervals of 14 and 20 days respectively). Four percent of the patients with impetigo have Group A streptococci in the throat. The pharynx is thus colonized later. It is evident that Group A streptococci in the nose and throat do not play any significant role as a reservoir in the acquisition and spread of this infection.[2]

Recovery of an impetiginous serotype from normal skin is associated with a high risk (76 percent) of subsequent development of lesions due to that type. Types 1, 2, 4, 12, 25, and 49 nephrogenic strains make up a small but significant part of this skin serotype. Although positive skin sites were found with nearly equal prevalence on the body, the predominance of leg lesions during the summer months suggests trauma, such as bug bites, which can be a major initiating factor in the development of impetiginous lesions. The high humidity of summer months also fosters the colonization of normal skin by these serotypes. Furthermore, persistence on normal skin of the same serotype of streptococci causing impetigo after the lesions have subsided suggests that frequent contamination or possible colonization of the normal skin by these organisms is a significant factor in this initiating process. As far as spread to other individuals, the mean interval from index to secondary skin acquisition of streptococci by a family member was 4.8 days.[2] The family member still has the highest risk of becoming infected, while classmates are less susceptible. There is no evidence that isolation of impetiginous patients is needed once local or systemic therapy has been started.

Glomerulonephritis

It is well known that infections due to Group A streptococci may lead to acute attacks of glomerulonephritis. Nephritis following a skin infection of Group A streptococci has a peak incidence in later summer and early fall; whereas nephritis and rheumatic fever have a peak incidence following streptococcal pharyngitis in the winter and spring. (Rheumatic fever has never been noted as a sequela

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to streptococcal pyoderma without a pharyngitis). Most patients with acute glomerulonephritis following a skin infection have the renal lesion when first seen, suggesting the initiation of the immunological process takes place with the onset of the lesions.[4] Glomerulonephritis has been noted after local and systemic antibiotic therapy of pyoderma and it remains to be clearly demonstrated that either route of therapy is more effective in reducing the attack rate of nephritis.[1] The excellent prognosis for healing of post-streptococcal glomerulonephritis in young children suggests that little prognostic information is gained from routine renal biopsy examination. With increasing age, however, examination of the renal biopsy is a useful adjunct for predicting prognosis.[5]

Treatment

Much of the recent literature on impetigo has revolved around the controversy of systemic versus topical treatment. Regardless of staphylococcal or streptococcal etiology, Burnett[6] found a much higher rate of treatment failures using combined neomycin and bacitracin ointment topically, compared to oral erythromycin. The "cure time" for the two methods was approximately the same. Hughes and Wan[7] made similar conclusions in a prospective study employing combined polymixin B-Bacitracin-neomycin (Neosporin)® against systemic erythromycin.

With the correlation between glomerulonephritis and streptococcal pyoderma being given increasingly more credence, Dillon and Esterly[8] and Markowitz[9] embarked on studies of systemic benzathine penicillin G versus topical ointments. Again, in both studies, the systemic treatment proved far superior, not only in effectiveness of cure but also in speed of response; 97 per cent of cures were effected within one week in the Dillion study.[4] Results were the same regardless of the lesion culture being streptococcus alone, staphylococcus alone, or both mixed. The presence in lesions of penicillin-resistant staphylococci did not interfere with the effectiveness of the penicillin, a fact long noted by other researchers.[9,10] Dillon[4] eloquently discounted anything but systemic treatment as follows: "Disadvantages of topical therapy included slower rates of healing, continued development of new lesions, failure to eradicate streptococci also present in the respiratory tract, and practical difficulties in application." Systemic penicillin G was also effective in limiting suppurative complications such as cellulitis and lymphadenitis. Conspicuously absent as claims for systemic or topical treatment of impetigo is any decrease in the incidence of the nephritic complication. Large enough studies have not been undertaken to make a statistically significant difference on this point.

Summary

Impetigo is now primarily a Group A streptococcal disease instead of S. aureus. The spread of this streptococcus is from normal skin and not from the throat. Specific serotypes are impetiginous. Treatment by systemic antibiotics is preferred, not because of the incidence of nephritis but because of a factor cure rate.

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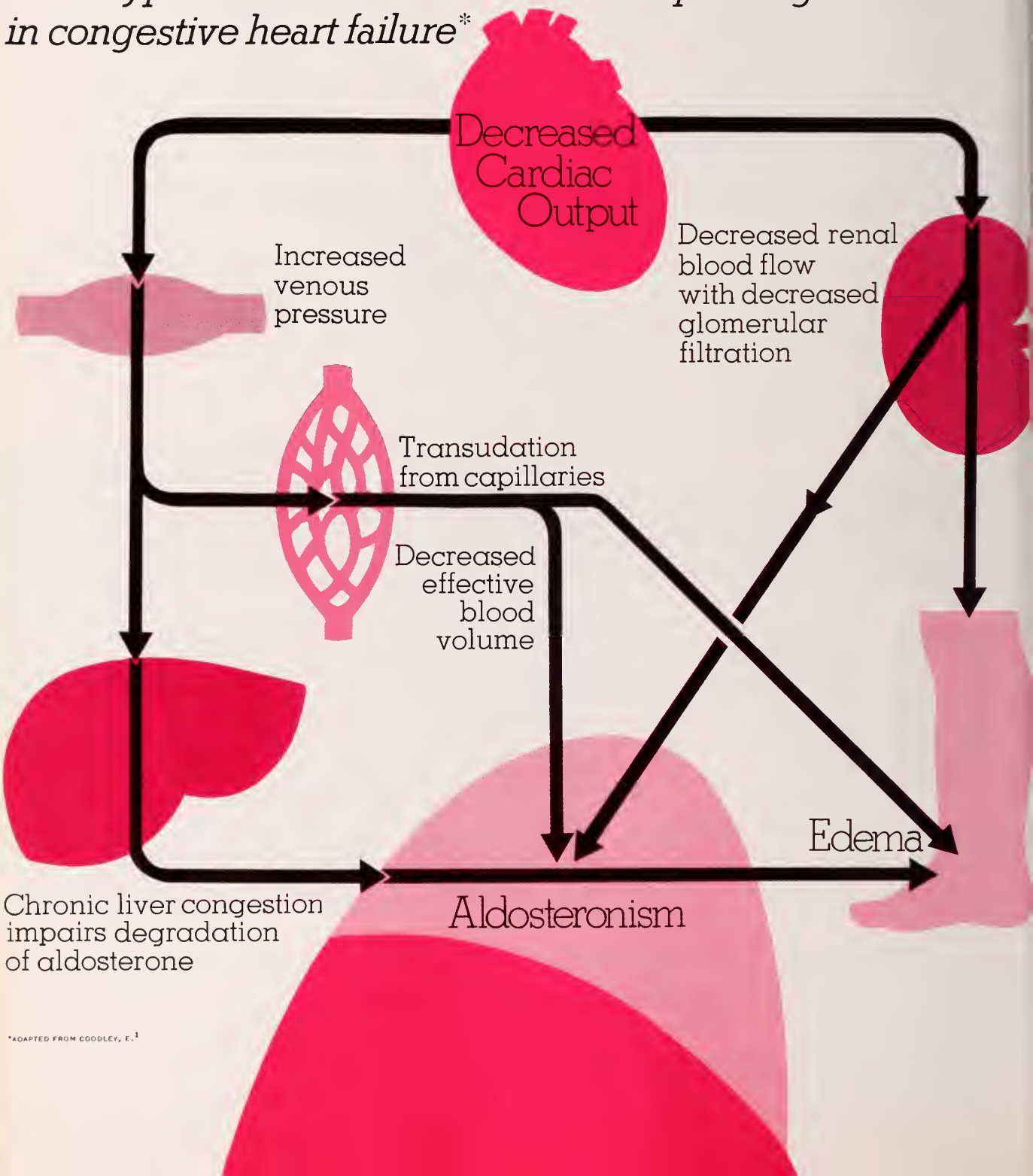

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- Avoids acute volume depletion and aldosterone rebound.[2]

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Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

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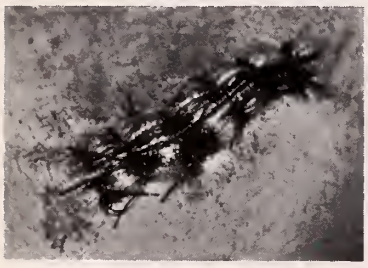

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A successful plastic surgical technique for correction of chronic lymphedema of the scrotum and penis is described. A unique feature of the operation is the use of split-thickness skingraft.

Chronic Lymphedema of the Scrotum and Penis

Louis L. Keeler, M.D. and William V. Harrer, M.D./Collingswood

Chronic lymphedema of the scrotum and penis is frequently encountered in the tropics, usually due to filariasis. This report concerns a patient who lived in the Philadelphia area. No etiologic agent was determined.

Case Report

A 52-year-old uncircumcised male was in France in World War II but denied any venereal disease or penile lesion. In 1949, the patient began to suffer with recurrent penile swelling, erythema, and pain, associated with purulent discharge and chills and fever. Initial treatment consisted of bed rest and aspirin. Antibiotics were prescribed, but the patient refused surgery.

Over the next several years the attacks became more frequent and severe and sexual activity ceased. The prepuce gradually became thickened, coarse, hard, and lobulated. During acute attacks a large amount of purulent material extruded from the foreskin, which the patient irrigated with a one cm. hose.

Physical examination of this obese male revealed a penis which was 12 inches long by 6 inches wide

Figure 1—Huge phallus—20x20x20 cm. with marked phimosis, lymphedema and elephantoid changes.

(Figure 1). Induration of the penile skin was greater than the scrotal skin. Cultures of urine were negative, but foreskin secretions yielded pseudomonas aeruginosa and staphylococcus epidermidis. CBC and SMA-12/60 were normal and serology (VDRL) was non-reactive. Thick and thin blood smears were negative for parasites. An intravenous urogram revealed a pyelonephritic left kidney and a markedly enlarged right kidney, dilatation of the distal two-thirds of the right ureter, and a small bladder.

Surgery was performed under spinal anesthesia; the foreskin and the skin of the shaft of the penis were removed (Figure 2), the scrotum was incised in the

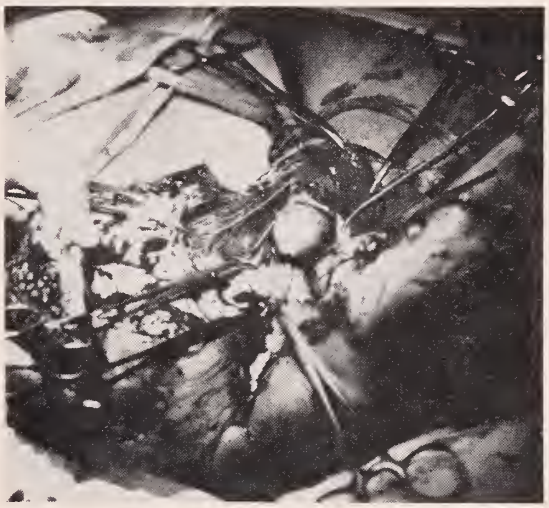

Figure 2—Note that once down to Buck's fascia all tissues are normal. The rest of the mass is elephantoid foreskin and subcutaneous tissue.

midline and a large amount of edema fluid was drained by manual compression. The scrotal incision was closed over a drain. A split thickness graft measuring 10 x 15 cm. and 1/18,000 of an inch in thickness, was taken from a non-hair bearing area of the left lateral thigh, wrapped around the penile shaft and sutured to itself on the dorsum. The coronal and abdominal skin were sutured to the graft. (Enough skin was used to allow for expansion.) A dressing was applied to maintain the penis in the erect position; a Foley catheter was left in place.

*Dr. Keeler is Clinical Assistant Professor of Urology and Dr. Harrer is Assistant Professor of Pathology at Jefferson Medical College, Philadelphia, and they are, respectively, attending urologist and director of laboratories at Our Lady of Lourdes Hospital, Camden.

Postoperatively, there was considerable drainage from the scrotal wound and the scrotum became noticeably smaller. The graft healed successfully and the patient was discharged two weeks after surgery. The result was excellent (Figure 3), including erections with sensation.

Gross examination of the specimen revealed a weight of 2,030 grams (Figure 4), marked dermal thickening and epidermal flattening. Histologically there was marked chronic dermatitis and perifolliculitis (Figure 5). The inflammation was comprised of many plasma cells, lymphocytes and histiocytes. Fibrous connective tissue proliferation, characterized by acidophilic staining collagenous bands and fibroblasts, was noted.

Figure 3—Two and a half months postoperative. Patient has normal erections, ejaculates, and has sensation during coitus.

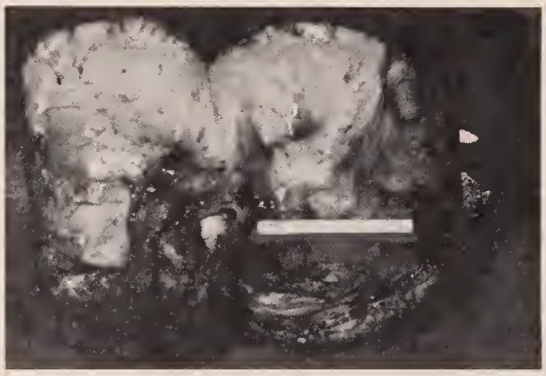

Figure 4—Gross specimen showing that the thickening is mostly subcutaneous tissue.

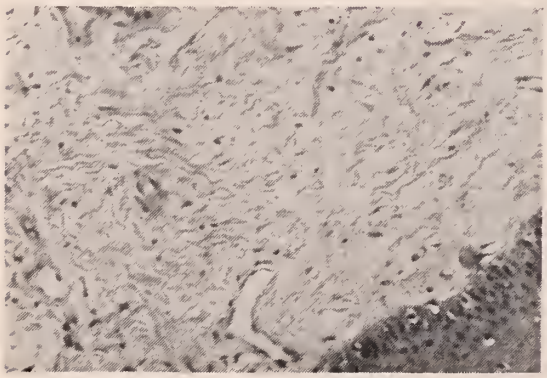

Figure 5—Microscopic appearance.

Discussion

Chronic lymphedema is primarily a disease of the subcutaneous tissues with secondary skin changes (Figure 2). Extracellular fluid enters the most distal portion of the lymphatics through the interstices of the subcutaneous tissues. The elephantoid changes begin distally in the most dependent areas, where the fluid appears to loculate, resulting in a collection of extracellular fluid which does not extrude when the tissue is cut. The secondary elephantoid skin change appears first with the "peau d'orange" resemblance due to edema in the dermis. Elephantiasis begins in the subcutaneous tissues and when edematous tissues become infiltrated with granulation tissue cells and strands of fibrous tissue, the lymphatics traversing the subcutaneous tissues from the dermis become sufficiently compressed to cause edema of the dermis (Figure 4).

Milroy[1] suggests that the bouts of chills and fever occurring in chronic lymphedema are in fact attacks of acute lymphangitis and that these are followed by obliteration of the lymphatics.

The success of the method of surgical management utilized confirmed the principles observed by others. A pedicle flap was not used because the subcutaneous fat in such skin makes the penis appear deformed and too large, and also because hair generally grows in the pedicle flap. The split graft is said to allow for more sensitivity during intercourse[3].

The graft was sutured to itself on the dorsal side of the penile shaft to avoid a hypospadic type deformity if the scar contracted. The scrotal skin which has an elastic quality was left in place in hopes that much of the edema would subside, and fortunately this happened. There is some question as to the wisdom of placing the testes in the thigh,[2] but if necessary, the two testes are sutured together and to Colles fascia. A small flap of posterior wall of the scrotum is saved, the testes are placed

on top of it, sutured together to form one regular mass and then skin grafted.[6]

Summary

A case of severe lymphedema with elephantoid changes in the penis and scrotum is presented. Surgical management was described.

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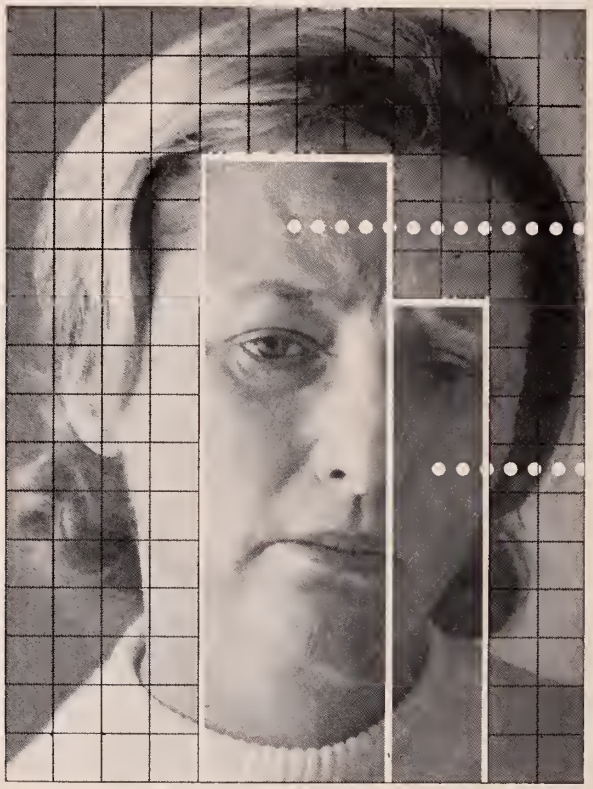

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For further information on this subject, the following references are provided:

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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

A combination of propranolol and other antihypertensive drugs seemed to have a better blood-pressure lowering effect, with fewer side effects, than drug combinations alone.

The Use of Propranolol with Various Drug Combinations in the Treatment of Essential Hypertension

Milton Shoshkes, M.D./Summit*

The use of combined vasodilatation with beta-adrenergic blocking agents offered a significant advance in the treatment of essential hypertension.[1] Hydralazine, a potent vasodilator and mild antihypertensive, was combined with propranolol in oral doses that had only mild antihypertensive effects singly. The combination produced an effective lowering of the blood pressure unassociated with serious or disabling side effects. This success was obtained in seventeen out of a group of twenty patients with a moderate or severe essential hypertension that had been unsatisfactorily controlled with a previous standard regimen. A similar success with this combined type of therapy was reported by Gottlieb, Katz, and Chiddsy[2] who used two potent vasodilators, minoxidil as well as hydralazine, and obtained a satisfactory response.

Stimulated by these promising reports, I have studied a group of private patients, who have been unresponsive to intensive, standard antihypertensive therapy.

Method

Seventeen patients, ranging in age from 33 to 78 years, were studied. Nine were males, eight were females, two were negroes, and the remainder were caucasians. They were selected on the basis of previous unresponsiveness to standard antihypertensive therapy which consisted of a diet restricted to 500 mg of sodium, plus antihypertensive agents which included Aldactone®, Ser-Ap-Es®, Ismelin®, and Esimil®, singly or in combination (See Table). Failure to respond to this treatment was based upon the inability to attain a blood pressure level of 140/90 or below or intolerable drug side effects. It had been found early in the course of treatment that adherence to a strict salt-restricted diet was critical. Since these patients were selected from a private practice panel, they were all ambulatory, usually working full time at their regular occupations, including homemaking. Although twelve patients had documented cardiovascular disease, none had serious central nervous system disease, such as vascular accidents, or serious renal disease. Associated hyperglycemia and hyperuricemia were successfully treated with appropriate regimens. The laboratory studies monitored before and during their studies included complete blood counts, urinalyses, serum levels of glucose, blood urea nitrogen, cholesterol, uric acid, chest x-rays, and a standard electro-cardiogram.

*This work is from Overlook Hospital, Summit, where Dr. Shoshkes is an associate in medicine.

Table

Summary of the Observations of the Patient Panel
Treatment Regimen and Results

Drug Key

Inderal®—Propranolol
Aldomet®—Methyldopa
Ser-Ap-Es®—Reserpine 0.1 mg
Hydralazine Hydrochloride 25 mg
Hydrochlorothiazide 15 mg
(Combination Tablet)
Ismelin®—Guanethidine Sulfate USP
Esimil®—Guanethidine Monosulfate 10 mg
Hydrochlorothiazide 25 mg
(Combination Tablet)
Apresoline®—Hydralazine Hydrochloride NF
Aldactone®—Spironolactone
Aldactazide®—Spironolactone 25 mg
Hydrochlorothiazide 25 mg
(Combination Tablet)

Age	Previous Drugs	Present Drugs	Previous Side Effects	B.P. Previous	B.P. Present
54	Inderal 10 mg. T-I-D Ser-Ap-Es T-I-D	Aldactone 25 mg. B-I-D Ismelin 10 mg. B-I-D Inderal 10 mg. B-I-D	Headache Lightheadedness	140/90	132/82
58	Aldomet 25 mg. Q-A.M.	Inderal 10 mg. Q-I-D Ser-Ap-Es Q-I-D	Abdominal pains	174/102	136/80
70	Ser-Ap-Es T-I-D Ismelin 25 mg. Q-A.M.	Ser-Ap-Es T-I-D Inderal 10 mg. T-I-D Ismelin 25 mg. Q-A.M.	None	160/96	124/76
72	Hydromox RQ-A.M. Aldactone 50 mg. B-I-D Ismelin 50 mg. Q-A.M.	Ser-Ap-Es T-I-D Inderal 10 mg. T-I-D	Abdominal pains Weakness	160/102	144/96
66	Ser-Ap-Es T-I-D	Ser-Ap-Es T-I-D Inderal 10 mg. T-I-D	None	170/80	134/80
71	Aldactone 50 mg. B-I-D Ismelin 50 mg. Q-A.M.	Ser-Ap-Es T-I-D Inderal 10 mg. T-I-D	Postural syncope Weakness, Diarrhea	170/96	140/96
72	Inderal 20 mg. Q-I-D Ismelin 60 mg. Q-A.M. Ser-Ap-Es Q-A.M.	Ismelin 100 mg. Q-A.M. Apresoline 75 mg. Q-I-D Esimil Q-I-D	Weakness, Nausea, Syncope	210/90	142/82
46	Ser-Ap-Es Q-I-D Inderal 40 mg. Q-I-D Ismelin 20 mg. Q-A.M.	Ser-Ap-Es Q-I-D Inderal 40 mg. Q-I-D Apresoline 50 mg. Q-I-D	Postural weakness	162/84	152/88
40	Aldactazide 2 T-I-D Ismelin 75 mg. Q-A.M.	Ser-Ap-Es T-I-D Inderal 20 mg. T-I-D	Impaired ejaculation	160/90	146/80
33	Aldactone B-I-D Ismelin 25 mg. Q-A.M.	Apresoline 25 mg. Q-A.M. Inderal 10 mg. Q-A.M.	Postural weakness	150/90	136/80
65	Aldactone 50 mg. Q-I-D Ismelin 50 mg. Q-A.M.	Aldactone 50 mg. Q-I-D Inderal 40 mg. Q-I-D Ismelin 25 mg. Q-A.M. Ser-Ap-Es Q-I-D	Postural syncope	190/90	136/84
78	Ismelin 40 mg. Q-A.M. Aldactone 50 mg. T-I-D	Ismelin 50 mg. Q-A.M. Aldactone 50 mg. T-I-D Inderal 20 mg. Q-I-D	Postural syncope	156/90	140/82
81	Ismelin 25 mg. Q-A.M.	Ser-Ap-Es Q-I-D Inderal 10 mg. Q-I-D	None	240/100	132/80
58	Ismelin 37.5 mg. Q-A.M.	Ser-Ap-Es T-I-D Inderal 10 mg. Q-I-D	None	202/100	138/88
71	Aldactone 25 mg. Q-I-D Ismelin 50 mg. Q-A.M. Aldomet 500 mg. Q-A.M.	Ser-Ap-Es Q-I-D Inderal 40 mg. Q-I-D	Postural syncope	160/90	156/90
70	Ismelin 35 mg. Q-A.M.	Aldactone 25 mg. Q-O-D Apresoline 75 mg. Q-A.M. Inderal 10 mg. Q-I-D	Postural syncope	134/80	140/80
61	Ismelin 50 mg. Q-A.M. Aldactozide B-I-D	Aldactone 25 mg. B-I-D Ser-Ap-Es T-I-D Inderal 10 mg. T-I-D	Impaired ejaculation	134/82	124/80

Results

The results are tabulated in the table. All of the patients tolerated propranolol well with no serious side effects of beta-adrenergic blockade being observed. A dosage up to 160 mg daily was attained in four patients. Fifteen of the seventeen patients obtained a satisfactory reduction in their previously poorly controlled hypertension. In one of the subjects, propranolol, when added to his regimen, proved less effective than a similar drug combination without it. In another patient, increasing the hydralazine to a total of 300 mg daily proved to be more valuable than adding propranolol. All of the thirteen patients who had suffered with serious or disabling drug-induced side effects on their previous therapy were freed of these reactions by using a combination therapy with propranolol. Satisfactory control of the blood pressure was evident in these thirteen, although two patients had a final systolic blood pressure over 150 and three had systolic levels ranging between 142 and 146 mm of mercury. In six patients, electrocardiographic changes improved significantly, but slight deterioration of the pattern was evident in four patients. Five patients showed reduction in heart size to normal by chest X-ray; increased heart size was not seen in any patient.

Discussion

The use of propranolol is ideal in some hypertensive patients who have been poorly responsive to standard therapy because of treatment failure or drug intolerance. Our patient group is typical of that seen in private practice; they are vigorous people who are vital to their families as breadwinners or homemakers. Previous therapy was partially successful, though at enormous cost of personal comfort; even physical dangers such as unpredictable hypotensive syncope were noted. The ease with which patients were transferred to this regimen was surprising.

Despite the obvious nuisance of taking medication four times daily for an indefinite period of time, these patients remained loyal to their treatment; none of the patients dropped out of the study. The major handicap to therapy was the critical need for absolute restriction of oral salt intake. Although a salt-restricted diet containing 500 mgs. of sodium was insisted upon, it was most difficult to obtain cooperation. Repeated exhortative educational attempts were necessary to obtain success.

The experience described in this limited series of seventeen patients should encourage us to continue the evaluation of propranolol in antihypertensive therapy.

Summary

Seventeen ambulatory hypertensive patients who had been unresponsive to standard antihypertensive therapy with drug combinations, supplemented by strict dietary salt restriction, were treated with the addition of oral propranolol in dosages of 40 to 160 mg daily. This beta-adrenergic blockage therapy was found to have a superior blood pressure lowering effect in fifteen out of seventeen patients, and was uniquely free of side effects. It is concluded that propranolol is a valuable addition in the combined antihypertensive therapy with multiple drugs.

The most gratifying experience was the ability to attain the goal of near normotensive levels or actual normal blood pressure readings in this series of patients who had been treatment failures before.

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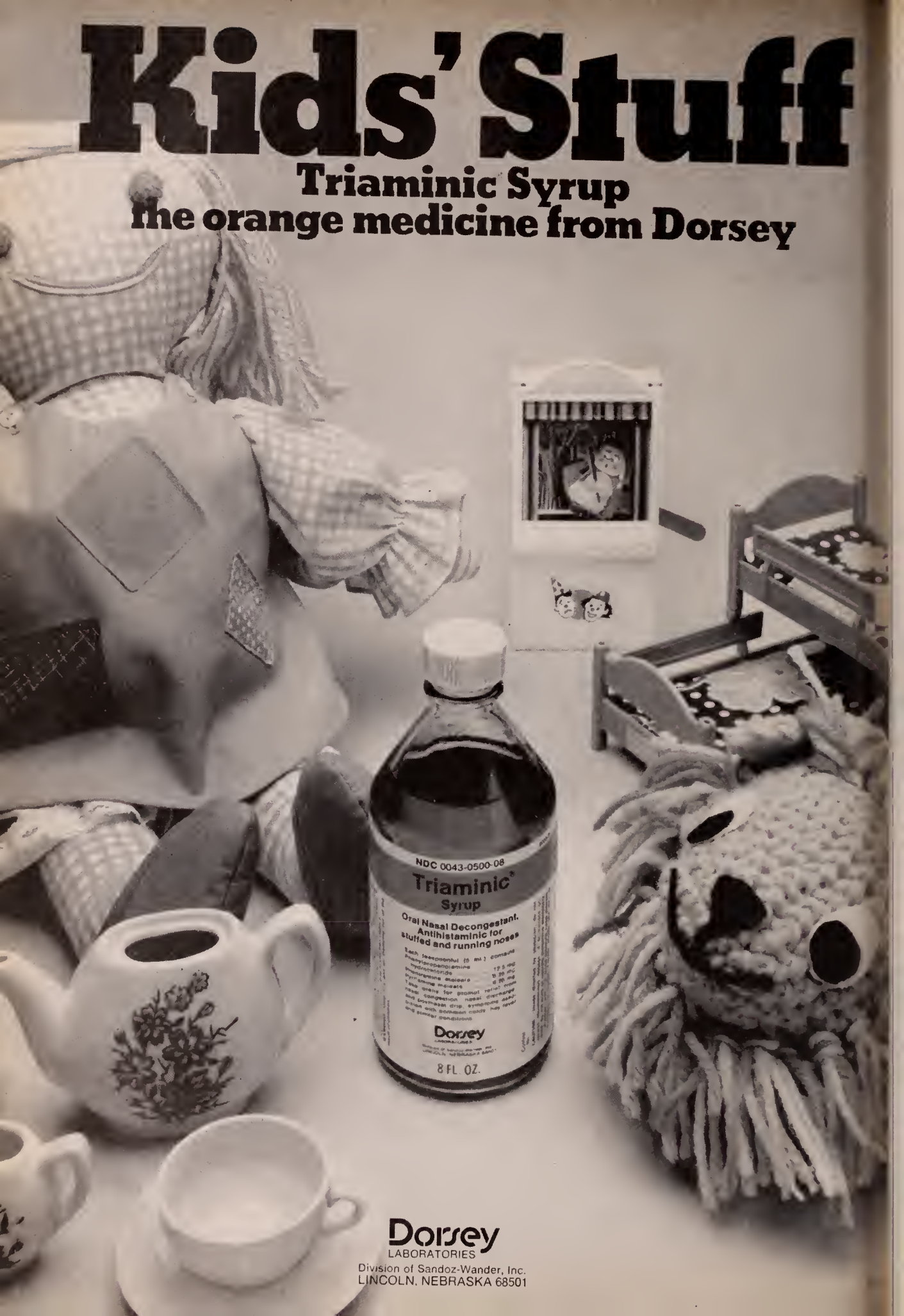

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HPL, which can be measured in pregnant women from the fifth week, shows a linear rise to a plateau at 36 to 38 weeks. A value of less than 4 micrograms per ml. after 35 weeks of gestation constitutes the "fetal danger zone." Serial values correlate with placental growth and function and may assist the obstetrician in the recognition of fetal distress and the decision as to time and mode of delivery.

Human Placental Lactogen in Evaluation of High Risk Pregnancies

Elijah Washington, M.D., et al./Newark*

One of the ultimate aims of an obstetrician should be the delivery of a healthy baby, mentally as well as physically. Because of the possibility of irreversible fetal damage during intrauterine life, we should attempt to minimize this possibility. Therefore, some method of evaluation or monitoring of the so-called "high risk" pregnancy appears to be of utmost importance.

One of the earliest and most frequently used of these methods is the determination of estriol levels in urine and plasma. Measurements of the fetal biparietal diameter to detect fetal growth retardation and amnioscopic observation of the amniotic fluid for meconium staining are also used as parameters of fetal well-being. Recently, the "oxytocin challenge test" at term has become popular as an additional indicator of uteroplacental insufficiency. This paper will review the present status of measurements of chorionic somatomammatropin, better known as "human placental lactogen" and will relate it to present obstetrical practice. Although the term chorionic somatomammatropin better describes the function of this hormone, it will be referred to as HPL which has wider acceptance.

HPL Isolation, Measurement and Function

Prior to the 1960's, many investigators had speculated on the lactogenic capabilities of the placenta. However, the only protein hormone isolated from the human placenta was human chorionic gonadotropin. In 1961, Higashi and Ito discovered a protein extractable from placentas which demonstrated lactogenic activity in pigeon crop sac assay.[1,2] The following year, Josimovich and MacLaren demonstrated the presence of a protein with lactogenic capabilities in the serum of pregnant women. They called the protein "human placental lactogen" and found it had partial immunologic similarity with pituitary growth hormone.[3] Subsequently, by immunologic fluorescence technique, it was demonstrated that the hormone was present in the cytoplasm of the syncytial trophoblast of the placenta.[4,5]

HPL can be detected in the serum of pregnant women as early as the fifth week of gestation. It has a continuous linear rise as pregnancy progresses, plateauing at the 36th to 38th week of gestation. The half-life of HPL is approximately 20 to 30 minutes; therefore it disappears rapidly following delivery and is virtually absent from the serum within 24 hours.[6 to 11] Studies of both the mammatropic and metabolic effects of HPL have been undertaken by the use of organ culture techniques. Like prolactin, HPL has been found to cause histologic development of mammary gland al-

*Department of Obstetrics and Gynecology, CMDNJ, New Jersey Medical School, Newark, where Dr. Washington is a resident. Coauthors are John Harrigan, M.D., Alvin Langer, M.D., and Cheng Hung, M.D., Assistant Professors at the College.

veoli in pregnant mice. Placental lactogen also caused milk formation when given to pregnant rabbits.[12,13] The apparent role of HPL in the human is to prepare breasts during pregnancy for lactation. However, because of its rapid disappearance from the serum following delivery, it does not play a part in subsequent lactation. HPL also performs a maternal metabolic role in pregnancy, mobilizing fat stores and sparing glucose for utilization by the fetus. It opposes insulin in this respect, and is a factor in the diabetogenic effect of pregnancy.[14,15] The placenta functions as an autonomous, endocrine organ during pregnancy, and its production of HPL is not dependent on a regulatory mechanism, such as the control by adenohypophyseal function of the production of pituitary growth hormone. It is thought that this autonomous function of the placenta in its production of HPL is designed to maintain satisfactory blood levels of glucose for fetal nutrition.

HPL Levels

Investigators have studied HPL levels in normal pregnancies and have found that HPL is primarily confined to the maternal compartment, where its levels are some 300 times higher than in the umbilical vein. This indicates that it does not freely cross the placental barrier, and that its effects are primarily on the mother and not the fetus.[8,15]

Serial samples of HPL during normal pregnancy show a linear rise as the pregnancy progresses with the greatest variability occurring during the last four weeks of gestation. The range, 4 to 12 micrograms/ml at 36 to 40 weeks gestation, is less than that of other indicators of uteroplacental function, such as estriol. The median value at 36 to 40 weeks of gestation is 6 to 8 micrograms/ml.[9,11,16] In the early literature on HPL, all observers found a linear rise; however, absolute values differed, depending on the method used in the determination. As methods have become standardized, values appear to be more uniform.

Since relatively few values occur below 4 micrograms/ml after 35 weeks of gestation, this has been termed the "fetal danger zone." However, the trend of serial values is more predictive of fetal compromise than any one isolated value. Values in the "fetal danger zone" which fail to rise, or declining values in the normal range, indicate fetal distress.

Early studies comparing placental weight with HPL levels resulted in conflicting reports. Some find correlation and others find no correlation.[9,11,16] Recently, extensive gross and microscopic examinations of placentas, taking into consideration quantity and vascularity of cytotrophoblast and deposition of functionally inert material such as fibrin, have shown close correlation of these parameters of placental function with HPL levels.[17]

Discussion

When one separates outpatients with hypertension, toxemia, renal disease, and postmaturity, HPL correlates well with fetal-placental size and fetal well-being. It will probably find its greatest utility in the management of problems of poor uteroplacental function. Patients with poor uteroplacental function will often have levels below the normal range, but if there is a continuing rise in levels as pregnancy progresses, fetal outcome has been good. Conversely, declining values have indicated fetal distress.

As more data appeared, it became obvious that abnormal pregnancies with large placentas, as in diabetes and Rh sensitization, tended to maintain levels of HPL in ranges considered normal for their period of gestation, even though fetal distress existed. While HPL levels are not predictive when in the normal range in the above conditions, significant drops in serial determinations are predictive of fetal compromise. HPL is of value when low or dropping, but does not guarantee a healthy fetus when in the normal range in the above conditions. In advanced stages of diabetes, vascular disease with uteroplacental insufficiency may result in a fetus and placenta which are small for the gestational age. In this group, one would expect to find HPL of predictive value.

Values below the normal range in any pregnancy should lead to other studies of fetal well-being, such as estriol determinations and amnioscopy, in an attempt to choose the correct time and method of delivery. In those fetuses in jeopardy from uteroplacental insufficiency from whatever cause, amniocentesis can be performed to assess maturity of the fetus by determinations of lecithin/sphingomylin ratios, creatinine levels and presence of fetal squames. Since the fetal pulmonary system matures more rapidly under stress, the fetuses are often prepared for extrauterine life. Meconium staining of the amniotic fluid would reconfirm fetal distress.

Once the time has been chosen for fetal exit from the uterus, a judgment must be made concerning the best method of delivery. With a severely affected fetus, cesarean section would probably be elected. If some doubt exists, the "oxytocin challenge test" may help. The test consists of electronically monitoring the patient and fetus to obtain a baseline, followed by uterine stimulation with minute amounts of oxytocin by intravenous drip. If the ensuing contractions produce late decelerations, the existence of uteroplacental insufficiency is confirmed. In instances of severe uteroplacental insufficiency, late decelerations occurring with Braxton-Hicks contractions have been detected prior to the infusion of oxytocin.

Letchworth and Chard monitored 333 pregnancies, of which 200 were clinically normal. In this large series they found very little overlap in the low range of HPL values between the normal and abnormal pregnancies. Specifically in patients with two samples below four micrograms per milliliter, 50 percent developed fetal distress. Seventy-five percent of patients with three or more samples below four micrograms per milliliter developed fetal distress. In extrapolating their results to the entire United Kingdom for one year, it was concluded that 36,000 cases of fetal distress, which were not detectable by usual obstetrical management could have been predicted.[18]

When used routinely during normal pregnancy, low or falling HPL will alert the obstetrician to fetal compromise which may not be obvious by history or clinical evaluation. When present, this will permit further evaluation of mother and fetus in an attempt to choose the correct time and mode of delivery.

Conclusions

HPL is primarily a measure of placental growth and function. As the placental mass increases in size, the HPL rises. Since HPL production also reflects placental function, it does not always rise proportionally with placental size. With conditions producing a large placenta, such as diabetes and Rh sensitization, it may not be a sensitive indicator.

In problems of uteroplacental insufficiency with small babies and small placentas, low HPL will indicate those fetuses at greatest risk. In this group, which includes toxemia, hypertension, chronic renal disease, and post maturity, the HPL is predictive of fetal distress and may give insight into the management of labor and delivery, with the option of cesarean section when needed.

HPL will probably assume a place among several other tests of fetal well-being which, when combined with increased clinical awareness of the problem of poor intrauterine environment followed by inappropriate labor and delivery, may assist obstetricians to eliminate cerebral palsy, minimal brain damage and the other sequelae of high-risk pregnancy.

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65 Bergen Street

Acupuncture Discredited as Cure for Deafness

Further evidence that acupuncture cannot cure nerve deafness is presented in scientific reports in the June issue of *Archives of Otolaryngology,* a publication of the American Medical Association.

Because of a surge of popular interest in acupuncture as a cure for deafness and a flow of patients to a half dozen acupuncture centers in the District of Columbia, the District Medical Society asked a group of its members specializing in ear problems to evaluate the technique.

The group reports on treatment of 123 ears of deaf or partially deaf patients who sought acupuncture, with the conclusion that "the data available in this study do not support the popularized notion that acupuncture cures deafness." More patients showed deterioration than improvement, they say. The Washington study is by David N. F. Fairbanks, M.D.

Another report in the same journal describes an effort to use acupuncture to cure deafness in a 63-year-old man in Chicago. Full measurements of hearing were made before and after treatment, and "there was no change in hearing level." This report is by Richard E. Marcus, M.D., and Robert A. Goldenberg, M.D. of the University of Illinois Eye and Ear Infirmary, Chicago.

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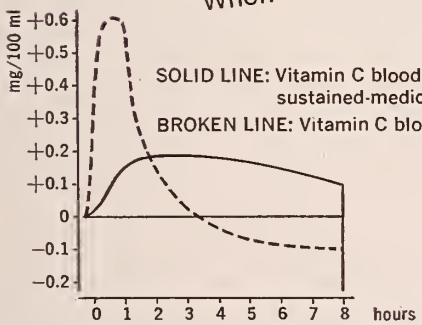

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WRITE FOR LITERATURE AND SAMPLES

BROWN **THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th St., Los Angeles, CA 90057**

REFER TO PDR

Questionnaires were mailed to 580 randomly selected Cumberland County resident' in an attempt to determine how well the services of the county Community Mental Health Center were known by residents; 102 questionnaires were returned. It was found that 83 per cent of the respondents claimed some knowledge of the Center. Income level and location of residence within the sample did not significantly affect level of awareness, although demographic data of the population surveyed did prove to be important. The clergy were named most frequently as a source of emotional help and newspaper advertising appeared to have been effective in increasing knowledge of one service. The results were compared with other studies and differences discussed.

Happiness Is Being Known

Irwin W. Kidorf, Ph.D. and Lisa N. Thomas, M.A./Millville

In order for a facility to meet the commitment of serving a community, the community should be aware of the services offered by that facility. The present study was undertaken to determine the extent of community awareness of a Mental Health Center which was recently expanded into a Comprehensive Center. This facility, serving a rural-urban county with a population of 121,000, had, for the past 10 years, provided out-patient psychiatric services. With the expansion, in-patient, partial hospitalization, emergency, and consultation services also are provided. The investigators were interested in learning if specific segments of the population have a greater level of awareness, for, if so, the implication would be that there are segments of the community who do not avail themselves of services because of ignorance of their existence. Previous studies (Goldman,[3] Heinemann[4]) indicate that over 80 per cent of the population in the catchment area had no knowledge of their Community Psychiatric Center. In these studies, the data were not analyzed in terms of demographic variables.

Based on the observation that very few black families seen at our Center are self-referred, it seemed important to learn if this were a "knowledge of the Center" variable, or if other factors were involved. Also, it was hypothesized that residents in urban areas, and those in the high income group would know more about the Center than rural and/or low income groups. Thus the demographic data assumed importance in the present study.

To add to the efficacy of education and consultative services to the community, the Center needed to be aware of the community's "gate-keepers." These are the people who are first contacted by county residents for help in times of emotional stress. Accordingly, respondents were given the opportunity of indicating who, in their judgment, would constitute the first contact when faced with a potential emotional problem.

Method

Subjects: 580 Cumberland County residents, chosen at random from the 1972 county directory, were sent questionnaires; 102 questionnaires were returned. Since subjects were asked to indicate family income level, residence (rural or urban), and race, it was possible to group respondents according to these variables. The percentage distribution of respondents was as follows:

Income Group	
Low	7%
Middle	32%
High	55%
Unidentified	6%
Residence Location	
Rural	51%
Urban	45%
Unidentified	4%
Race	
White	95%
Non-white	5%

Table 1

A Summary of Median Attitude and Knowledge Scores for 102 Subjects Who Returned Questionnaires

Item	Income Group			Residence Group		Black	Over-all
	Low	Middle	High	Rural	Urban		
Median Knowledge Score	4.33	3.75	4.77	3.88	4.75	5.0	4.33
Median Attitude Score	3.75	2.28	2.07	2.33	3.18	3.0	2.88
Number of Subjects	7	33	56	45	51	5	102

Procedure: Subjects were sent questionnaires containing seven questions with multiple choice answers. One of these items described an emotional crisis and subjects were asked to indicate who they would recommend be called in that situation. Available choices were: the Guidance Center, the local general hospital, the family doctor, a private psychiatrist, a clergyman, or the police. Four additional items were designed to measure the extent of the subjects' knowledge of the Center, resulting in knowledge scores ranging from 0-9. Two items were included to assess the subjects' attitude toward the Center. Scores were obtained ranging from +4, the most positive attitude score, to −4, the most negative.

Results

Of the respondents, 83 per cent indicated they had heard of the Center. On the basis of the sample size, the probability is .95 that the true percentage of people in the county who have heard of the Center is between 75.5 and 90.5 (Buell[1]). Sixty-six per cent of the respondents obtained a knowledge score of 5 or more, indicating that they had some specific knowledge about the Center. There was a tendency toward lower knowledge scores in the middle income group. On the attitude scale, 81 per cent had scores of +2 or more, indicating a moderately favorable attitude. There were no significant differences in median attitude or knowledge scores between the urban and rural groups, or among the low, middle, and high income groups. Table I summarizes the median attitude and knowledge scores for the various sub-groups. Since there were only five black respondents, no statistical tests were run on that data. It was noted, however, that the median scores were very close to the over-all medians.

Weekly counselling was the best-known service offered by the Center. It was known by 76 per cent of the respondents. Therapy for children and the 24 hour emergency telephone service were known by 55 per cent of the respondents, while day hospitalization was known by 20 per cent and full-hospitalization was known by 14 per cent.

As indicated in Table 2, the clergy was named most frequently as the primary source to turn to in times of emotional crisis. Other sources, in decreasing frequency were the Guidance Center, family doctor, private psychiatrist, and hospital. None of the respondents would notify the police.

Table 2

Frequency With Which Each Facility Was Recommended By 102 Respondents as a Place to Turn for Help in a Time of Emotional Crisis

Facility	Frequency of Recommendation
Clergy	52
Guidance Center	38
Family Doctor	30
Private Psychiatrist	20
Hospital	2
Police	0

Discussion

Our study suggests that a majority of residents in Cumberland County are aware of the presence of their Community Mental Health Center and have a favorable opinion of it. This finding contrasts sharply with findings of other surveys, (Heinemann,[4] Goldman[3]) which have found that only a small percentage of their populations were aware of their mental health center. One factor may be the difference in the type of populations surveyed. Both Heinemann and Goldman surveyed populations which were composed of predominantly low-income blacks, living in the inner city. The population in the current study is less homogeneous. The Cumberland County

population has a median family income of $9,529. There is a rather wide ethnic variety in the county as thirteen per cent are black and 18.5 per cent claim "foreign stock," that is, of foreign birth or having at least one foreign born parent. (Burks[2]) The County has many rural residents whereas the other populations surveyed were entirely urban.

The discrepancy between our results and previous studies could also be partly explained if the sample used in this study were biased due to the method of surveying used. It is possible that people who know about the Center were more likely to return the questionnaire than those who had not heard of the Center. Thus the sample might reflect a higher proportion of subjects with knowledge than actually exists in the population.

The returns show that the income distribution of the sample is significantly different from the income distribution of the population ($\chi^2.05=5.99$, $\chi^2 obs=6.07$). The percentages of families at each income level in the sample and in the population are given in Table 3.

Table 3
Per cent of Families in Three Income Groups In the Sample and in the County Population

Income Level	% In Sample	% In County
Low (below $3,999/Yr.)	7	13
Middle ($4,000-9,999/Yr.)	32	40
High (Over $10,000/Yr.)	55	46
Unidentified	6	1

The portion of families in the high income group is higher in the sample than in the population, while low-income families are under-represented. The proporton of blacks in the sample is also considerably smaller than the proportion of blacks in the population.

The lack of response from black and low-income families could indicate: (1) that many in these groups have not heard of the Center; (2) that they are not interested in the general problem of mental health; and (3) that they are not amenable to the questionnaire method of surveying. Probably a combination of these factors is involved. Further research is planned to try to determine the reasons for the lack of response from these groups.

Although there are limitations to our confidence in generalizing from the sample, some of the findings are still interesting. It was found that of the services offered by the Center, the oldest service, counseling, was known best. This finding was expected since the Center had offered weekly counseling for ten years. Of newer services, the Emergency Telephone Service was known best. Since this was the only service which was advertised extensively in the local newspapers, it was concluded that advertising had been effective in increasing the awareness of the community of that service. Goldman[3] found that direct mail advertising did not raise the level of awareness of his Center in the general population of the catchment area. The present findings indicate that newspaper advertising, a more economical form of disseminating information, can be effective.

Our finding that the clergy is the most frequently named source for help with emotional conflicts is an interesting one. It differs from the conclusions of Ring and Schein[5] and Heinemann,[4] both of whom found that the clergy was infrequently named as a source of help. It does support the findings of the Joint Commission of Mental Illness and Mental Health, 1961, which showed that 42 per cent of people in need of help turn to clergymen, 29 per cent to a physician, and 18 per cent to a psychologist or psychiatrist. These different findings probably reflect differences in the types of population surveyed since Ring and Schein,[5] as well as Heinemann,[4] surveyed predominantly urban black population.

Although there are limitations in the degree of confidence with which we can generalize from our sample to the entire population of the county, the results do suggest that this community mental health center is better known in its community than some of the centers previously studied are known in theirs. One reason for this may be that the population of this county has characteristics different from the populations previously sur-

veyed. Demographic data supports such differences in ethnic composition and income distribution. It is not unreasonable to speculate that such variables are related to differences in attitude toward mental health and degree of awareness of community resources. The findings regarding the frequent reliance on the clergy as a source of help and the apparent efficacy of newspaper advertising in increasing community awareness of service bear implications for future educational and public relations efforts. Further research is planned to determine if the Center is meeting the needs of the groups under-represented in the sample and also to determine the extent to which the local clergymen are aware of the Center's services. The investigators feel that while the questionnaire method of survey is adequate in obtaining an estimate of consensual thinking, direct contact would provide a more reliable assessment of the Center's impact on the community.

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R.D. 1, Carmel Road

Epidemiology of Cerebral Infarction

Although cerebral infarction may be precipitated by different conditions, such as atherosclerotic occlusion of an intracerebral artery or an embolus originating from an atherosclerotic plaque in an internal carotid artery, or from a diseased heart valve, there are certain epidemiological factors which are important. Medical literature on stroke which was based on autopsy material has distorted prevalence data. Population studies, including autopsy data, indicate that "nearly 80 percent of all strokes are due to cerebral infarction with or without evidence of embolism." Only 10 percent of strokes are due to intracerebral hemorrhage, and 70 percent to subarachnoid hemorrhage.

Survival data discolosed that 82 percent of patients with cerebral infarction survived 30 days or more, although long-term survival of such patients was decreased as compared to expected survival of life tables. Late death was mainly due to heart disease rather than recurrent stroke. Post-stroke morbidity data of patients who survived six months was encouraging, however, disclosing that 28 percent of survivors of cerebral infarction were "normal" while an additional 37 percent were working or able to work (unless age precluded work), despite a residual neurological deficit.

The major risk factors for cerebral infarction have been shown to be age, hypertension, cardiac disease (especially coronary artery disease), and transient ischemic attacks (T.I.A.). Other factors, such as elevated blood lipids (cholesterol, triglyceride), hyperglycemia, obesity, cigarette smoking, and decreased physical activity, have not been shown to have a clear relationship to cerebral infarction.

*Whisnant JP: Epidemiology of cerebral infarction. *Stroke,* 9:1-4, 1974

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

May 10 and 14, 1974

Two regular meetings of the Board of Trustees were held during the 1974 Annual Meeting in Atlantic City. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

May 10, 1974

Cancer Registry Workshop . . . Concurred in the President's action of approving cosponsorship, without financial commitment, of the American College of Surgeons' Workshop on the Hospital-Based Cancer Registry, held at St. Barnabas Medical Center early in June.

Certificate of Need . . . Noted that MSNJ's Executive Committee and representatives of the Health Care Administration Board will meet for discussion of the matter of certificate of need, on May 22, 1974.

New Jersey Hospital Association . . . Received as informative a report submitted by Dr. John S. Madara, MSNJ liaison, of the May 8, 1974 meeting of the Board of Trustees of the New Jersey Hospital Association, with special notation of the following:

> The NJHA Board of Trustees opposed a letter from the Commissioner of Insurance and the Acting Commissioner of Health to New Jersey Hospitals requesting a cut-back on further improvement in quality of care by one half.

. . . Directed that a copy of the letter in question be obtained and reviewed and that a report be made at a subsequent meeting.

Store Front Health Facilities . . . Noted that representatives of the Passaic County Medical Society were unable to attend a meeting arranged by MSNJ with the Board of Medical Examiners concerning store front health facilities in Passaic County and suggested that such a meeting be held (May 12) during the convention.

Nominations to State Board of Medical Examiners . . . Directed that the name of Carl N. Ware, M.D. be submitted to the Governor as nominee to the State Board of Medical Examiners, to succeed himself.

. . . Noted that Dr. John J. McGuire had been appointed to the State Board of Medical Examiners to succeed Dr. Hubert Humphrey whose term expired on March 13, 1974.

Recent Medical School Graduates . . . Directed that a one-year study, prepared by Dr. Louis Albright, on the number of foreign-trained and American-trained medical graduates who have become members of MSNJ be referred to *The Journal* for publication as soon as possible.

May 14, 1974

Introduction of New Members . . . Welcomed William Greifinger, M.D., 1st District; John J. Crosby, Jr., M.D., 2nd District; and Sherman Garrison, M.D., 5th District, as new members of the Board of Trustees.

. . . Noted that Frank R. Begen, M.D., was elected to the office of Second Vice-President; that Charles L. Cunniff, M.D., was elected to the office of Secretary, and that Samuel J. Lloyd, M.D., was re-elected to the office of Treasurer.

Reorganization of the Board . . . Elected David Eckstein, M.D., Chairman of the Board for 1974-1975; elected Francis Benz, M.D., Secretary of the Board for 1974-1975; agreed to continue meeting regularly at 10:45 a.m. on the third Sunday of each month in the Executive Offices (meeting subject to cancel-

lation should the agenda prove insufficient), elected James S. Todd, M.D., as Board of Trustees member on the Committee on Finance and Budget for a three-year term (1974-1977); re-elected John J. Bedrick, M.D., and Joseph J. Kline, M.D., to membership on the Committee on Physicians' Relief Fund for three-year terms (1974-1977).

Investigation of Pharmacies . . . Agreed, as in previous years, to comply with a request of the Board of Medical Examiners to supply the names of 25 physicians willing, on request, to provide prescriptions for drugs to be used as part of an investigatory procedure covering certain retail pharmacies suspected of violating statutes regarding the dispensing of drugs.

Consultation with MSNJ's Councils and Committees (Resolution #2, 1974 House of Delegates):

RESOLVED, that the House of Delegates sternly affirm that the Board of Trustees of The Medical Society of New Jersey must consult, in a meaningful fashion, its own councils relating to the various aspects of medical practice in the state, and, in addition, consult those recognized organizations representing bonafide groups of physicians such as the New Jersey Psychiatric Association or the American Academy of Family Physicians, etc., when the interests of such physicians come before the Board of Trustees.

. . . Acknowledged receipt of Resolution #2 and directed that the Passaic County Medical Society be so notified.

Establishment of Compulsory Membership in the American Medical Association (Resolution #29, 1974 House of Delegates):

RESOLVED, that membership in the American Medical Association be established as a condition for continued membership in The Medical Society of New Jersey and its federated county medical societies.

. . . Directed that (a) the AMA be notified of the action of the House; (b) the President, Secretary, Treasurer, and Executive Secretary of each component county medical society be notified that this is to be implemented in January 1975, and (c) the resolution be referred to the Standing Committee on Revision of Constitution and Bylaws for drafting of the appropriate amendment to the Bylaws to conform to the established position of the Society.

Establishment of a Physicians' Bill of Rights (Resolution #34, 1974 House of Delegates):

RESOLVED, that this House of Delegates adopt the Physicians' Bill of Rights as its official policy; and be it further

RESOLVED, that this statement be communicated through the American Medical Association to insurance companies, hospitals, and to the patients.

. . . Directed that Resolution #34 be referred to the New Jersey Delegation to the AMA for drafting of an appropriate resolution to be submitted to the AMA.

Amendment of PSRO and Evaluation of the New Jersey Foundation for Health Care Evaluation (Resolution #6, 1974 House of Delegates):

RESOLVED, that The Medical Society of New Jersey re-examine and re-evaluate the function of the New Jersey Foundation for Health Care Evaluation as related to its wishes and the authority granted it; and be it further

RESOLVED, that The Medical Society of New Jersey actively seek to have the PSRO law amended.

. . . Directed that Resolution #6 be referred to the Executive Committee for implementation, that the AMA be requested to supply MSNJ with its official list of suggested amendments to PL 92-603, and that the New Jersey Delegation to the AMA be notified of MSNJ's support of amendments to that law.

Federal Catastrophic Health Insurance (Resolution #9, 1974 House of Delegates):

RESOLVED, that The Medical Society of New Jersey request the American Medical Association, through resolution at the June 1974 AMA Convention, to assume the leadership in this field; and be it further

RESOLVED, that the AMA draft, and actively seek, implementation of a catastrophic health-care plan as a separate legislative entity which would provide federal assistance to those with unduly burdensome health-care financial problems; and be it further

RESOLVED, that, if across-the-board catastrophic coverage is introduced from other sources and is one that can be lived with by the private sector, that the AMA lend this legislation its unequivocal and vocal support.

. . . Acknowledged receipt of Resolution #9 and directed that the Essex County Medical Society be so informed.

. . . Directed that Resolution #9 be referred to the New Jersey Delegation to the AMA for drafting of an appropriate resolution.

Amendment to Lien Law (Resolution #14, 1974 House of Delegates):

RESOLVED, that the law of liens pertaining to physicians be amended to permit the existence of a lien on proceeds due the insured patient under the provisions of the personal liability section of his automotive insurance policy, this being for legitimate services rendered to the insured by the treating physician.

. . . Directed that Resolution #14 be referred to the Legislative Analyst for drafting of appropriate legislation for presentation to the Council on Legislation.

Laboratory Services Billing Act (Resolution #15, 1974 House of Delegates):

RESOLVED, that The Medical Society of New Jersey seek to have the law amended to require that any physician, dentist, osteopath, podiatrist, chiropractor, bioanalytical laboratory or hospital laboratory which refers blood or other specimens to another clinical or bioanalytical laboratory shall disclose the cost of such laboratory tests to the patient or third-party payers.

. . . Directed that Resolution #15 be referred to the Legislative Analyst for drafting of appropriate legislation for submission to the Council on Legislation.

School of Professional Psychology (Resolution #24, 1974 House of Delegates):

RESOLVED, that The Medical Society of New Jersey actively oppose the formation of a School of Professional Psychology.

. . . Directed that Resolution #24 be referred to the Council on Mental Health for consideration and report to the Board on development of an appropriate presentation of MSNJ's position of opposition to the school of professional psychology.

Medically Indicated Abortion Reimbursement (Resolution #38, 1974 House of Delegates):

RESOLVED, that The Medical Society of New Jersey actively support the right of all women to receive third-party payments for abortions.

. . . Directed that the sponsor of Resolution #38 be requested to approve two changes which would not alter the intent of the resolution, but would result in more accurate language, to read:

RESOLVED, that The Medical Society of New Jersey actively support the right of all pregnant women to receive third-party reimbursements for abortions.

. . . Directed further that, after the sponsor's approval of the above, Resolution #38 be referred to the Council on Medical Services for drafting of a position statement.

Committee to Investigate Tissue Banks (Resolution #25, 1974 House of Delegates):

RESOLVED, that a committee be appointed by MSNJ; and be it further

RESOLVED, that this committee investigate and compile a list of various tissue banks and their location to be available to physicians who may require various organs for surgical transplantation and to others who wish to donate certain organs upon their demise.

. . . Directed that Resolution #25 be referred to the Council on Public Health.

Opposition to Tocks Island Dam Project (Resolution #39, 1974 House of Delegates):

RESOLVED, that The Medical Society of New Jersey oppose the Tocks Island Dam Project until such time as all environmental issues have been satisfactorily resolved, and be it further

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey be directed to communicate our position to the Governor, the Department of Environmental Protection, and other appropriate agencies.

. . . Directed that the appropriate communications be sent to those organizations listed in the resolution.

Committee on Publication . . . Approved the following recommendation from the Committee on Publication:

That advertisers in *The Journal* who use 12 or more color pages a year in the form of 2, 4, or 8-page furnished inserts be authorized a 20 percent discount during the period July through December 1974.

Caution on Methadone Maintenance

The following is quoted from a resolution (#22—Methadone Maintenance) presented by the Essex County Medical Society and adopted by the 1974 House of Delegates, MSNJ, meeting on May 14, 1974:

"RESOLVED, that The Medical Society of New Jersey instruct its members that it is not in the best interest of patient care for individual physicians to request permission from the Bureau of Narcotics and Dangerous Drugs to operate their own methadone program."

New Members MSNJ— May 1973 to May 1974

(The following compilation was prepared by the then Secretary of MSNJ, Louis F. Albright, M.D., and is here presented for the information of the membership.)

There were 428 graduates of both American and foreign medical schools who became new members of The Medical Society of New Jersey during the period of May 1, 1973 to May 1, 1974. These new members can be classified into four main groups, on the basis of citizenship and locale of graduation. (Table 1)

Table 1
New Members of The Medical Society of New Jersey

	Native Born Citizens	*Naturalized Citizens*	*Non-Citizens*	*Totals*
Graduates of American Schools	225	0	0	225
Graduates of Foreign Schools	21	*26	156	203
Total Graduates	246	26	156	428

*All 26 became naturalized citizens after their graduation from a foreign school

The largest group, 225 native-born American citizens, were graduated from 52 American medical schools. (Table 2)

Table 2
American Graduates

School	*Number*
Jefferson Medical College	21
New Jersey College of Medicine and Dentistry	17
New York Medical College	15
New York University	14
SUNY at Brooklyn, Downstate	12
Hahnemann Medical College	12
Temple University	12
University of Pennsylvania	12
Columbia University	8
Albert Einstein College of Medicine	6
SUNY at Buffalo	6
Medical College of Pennsylvania	6
Georgetown University	5
SUNY at Syracuse, Upstate	5
George Washington University	4
Howard University	4
Medical College of Virginia	4
Tufts University School of Medicine	4
Boston University	3
University of Chicago Pritzker School of Medicine	3
Harvard Medical School	3
University of Pittsburgh	3
Albany Medical College	2
Chicago Medical School	2
Cornell University	2
Indiana University	2
University of Illinois	2
University of Louisville	2
University of Maryland	2
University of Michigan	2
Ohio State University	2
University of Rochester	2
Loyola University Stritch School of Medicine	2
Vanderbilt University	2
University of Vermont	2
University of Virginia	2
Yale University	2
Baylor University	1
Bowman-Gray School of Medicine	1
University of California, Los Angeles	1
Emory University	1
University of Florida	1
Medical College of Georgia	1
State University of Iowa	1
University of Kentucky	1
Loma Linda University	1
Long Island College of Medicine	1
University of North Carolina	1
New York Polyclinic Medical School	1
Medical College of South Carolina	1
Saint Louis University	1
University of Texas	1
Tulane University	1
	Total—225

There are 21 native-born American citizens, who were graduated from 14 foreign medical school in 8 countries. (Table 3)

Table 3
American Citizens Graduating from Foreign Medical Schools

Country	*Medical School*	*Number*
Switzerland	University of Berne	2
	University of Basel	1
	University of Lausanne	1
	University of Zurich	2
Italy	University of Bologna	4
	University of Padova	2
	University of Rome	1
Netherlands	University of Amsterdam	2
Canada	Dalhousie University	1
	McGill University	1
Chile	University of Chile	1
Belgium	University of Belgium	1
China	Tung Teh Med. College, Shanghai	1
France	Faculte Mixte de Med. an Pharm. Marseilles	1
		Total—21

The second largest group were 156 graduates of foreign medical schools. All of these were citizens of foreign countries and had signed a "declaration of intent" to become American citizens. The countries represented by these foreign graduates are shown in Table 4.

Table 4
Non-Citizen Graduates of Foreign Medical Schools

Country	*Number*	*Medical Schools Represented*
Philippines	54	7—(There were 30 graduates from the University of Santo Tomas and 11 from Far Eastern University.)
India	34	26—(The most from any one school were 3 from Grant Medical College in Bombay.)
Korea	9	5—(There were 3 graduates from the Seoul National University School of Medicine.)
Taiwan	9	5—(There were 4 graduates from National Taiwan University College of Medicine.)
Iran	8	3—(6 graduates from Tehran University.)
Pakistan	8	3—(6 graduates from Ling Edward Medical College, Lahore.)
Egypt	4	3—(2 graduates from University of Cairo.)
Thailand	4	3—(2 graduates from University of Medical Sciences, Siriraj, Bankok.)
Indonesia	3	3
Cuba	2	2—(University of Havana Medical School.)
Colombia	2	2—(National University, Bogata.)
Argentina	"	2—(University Buenos Aires.)
Peru	2	2—(San Marcos University, Lima, and Cayetano Heredia Medical School. Lima.)
Spain	2	2—(University of Madrid.)
Czechoslovakia	1	1—(Kemensky University, Bratislava.)
Austria	1	1—(University of Vienna.)
Australia	1	1—(University Melbourne, Victoria.)
Dominican Republic	1	1—(Santo Domingo Medical School.)
Ecuador	1	1—(University of Guayquil.)
Israel	1	1—(Medical School of Hebrew University.)
Italy	1	1—(University degli Studi di Napoli.)
Mexico	1	1—(University of Mexico.)
Nicaragua	1	1—(National University of Nicaragua.)
Roumania	1	1—(Institute Medicine and Pharmacy, Bucharest.)
South Africa	1	1—(Durban Medical School.)
Syria	1	1—(Damascus University.)
West Germany	1	1—(University of Teubingen.)
27 Countries	156 graduates	77 Medical Schools

The last group to be studied were the 26 foreign-born graduates of foreign medical schools who have become naturalized American citizens in the years following their graduation. All of this group were graduated a number of years ago, usually prior to 1965 and many before 1955. Almost all have resided in this country for a number of years and most have been practicing in other states before coming to New Jersey to practice and to seek admission to The Medical Society of New Jersey. The countries of origin and schools of graduation are shown in Table 5.

Table 5
Graduates of Foreign Medical Schools Naturalized Since Graduation

Country	*Medical School*	*Number*
India	Bombay University	1
	M.G.M. Medical College, Indore	1
	Toniwala National Medical College, Bombay	1
Italy	University of Naples	1
	University of Rome	1
Canada	University of British Columbia	1
	University of Toronto	1
England	Middlesex Hospital Medical School	1
	Leeds University	1
Austria	University of Innsbruck	1
Dominican Republic	University of Santo Domingo	2
Egypt	University of Cairo	2
Germany	University of Heidelburg	2
Haiti	Faculte of Medicine, Port au Prince	1
Israel	University of Tel Aviv	1
Netherlands	University of Amsterdam	1
Philippines	University of the East	1
Poland	Academy of Medicine, Warsaw	1
Roumania	University of Clerf	1
Spain	University of Madrid	2
Switzerland	University of Basel	1
Uruguay	Faculte of Medicine, Montevideo	1
17 Countries	22 Schools	26 graduates

Academy of Medicine Awards

At the annual Awards Dinner held on May 29, 1974, Dr. Arthur Bernstein, President of the Academy of Medicine of New Jersey, announced that Henry M. Kennedy of South Orange was the recipient of the annual Citizen's Award and presented the Edward J. Ill Award to Dr. Louis F. Albright of Spring Lake.

Louis F. Albright, M.D. (l), Award recipient, and Academy President Arthur Bernstein, M.D.

Dr. Albright was honored for his dedication and extraordinary service to the medical profession and to the citizens of the State of New Jersey. The Spring Lake cardiologist is a graduate of Hahnemann Medical School and is a diplomate of the American Board of Internal Medicine and of the American Board of Cardiovascular Diseases. He is also a Fellow of the American College of Physicians, and a member of the Council on Clinical Cardiology of the American Heart Association.

Dr. Albright, who has just resigned after serving four years as secretary of The Medical Society of New Jersey and who is a delegate to the American Medical Association, is president of the Monmouth-Ocean County Health Facilities Planning Council and president of the Monmouth County Advisory Committee for Comprehensive Health Planning. A member of the Review Committee of the State Health Planning Council of New Jersey, Dr. Albright served as president of the New Jersey Heart Association, Monmouth County Medical Society and the board of governors of the Brisbane Child Treatment Center, Allaire. A former chief of staff of the Jersey Shore Medical Center, he now serves as a member of its board.

Mr. Kennedy was cited as "a citizen of New Jersey who has contributed in an outstanding fashion to the solution of health and health care problems in the state." A cum laude graduate of Princeton University, he retired in 1970 as vice president in charge of advertising and publications for the Prudential Insurance Company and is currently serving as vice president of the New Jersey Regional Medical Program.

Dr. Edmund D. Pellegrino, chancellor of the Medical Units and vice president for Health Affairs of the University of Tennessee Medical Units, was the guest speaker at the dinner. Dr. Pellegrino, the former dean of the State University of New York Medical School at Stoney Brook, New York and former medical director of Hunterdon Medical Center, Flemington, was awarded an Honorary Doctor of Science Degree in 1973 by the College of Medicine and Dentistry of New Jersey.

Mrs. Henry A. Davidson of East Orange accepted a special Presidential Seal which was presented to her in honor of her late husband, Dr. Henry A. Davidson, who died in August of 1973 while still serving his term as president of the Academy.

The Academy of Medicine of New Jersey has as its primary objective the sponsorship and coordination of continuing medical education programs for New Jersey physicians and dentists. All Academy-sponsored and co-sponsored medical programs are accredited by the American Medical Association for Category 1 credits and all dental programs by the American Academy of General Dentistry.

New Jersey Commission for Blind and Visually Impaired

(The following was prepared by Anthony M. Sellitto, M.D., Medical Administrative Consultant to the Commission)

A legally blind person is one who has vision of 20/200 or less in the better eye with correction, or who has a peripheral field of vision restricted to 20° or less. All persons within this definition must be referred to the Commission according to the Statutes of New Jersey. Doctors should be cognizant of the services provided by the New Jersey Commission, these include education, rehabilitation, and prevention.

In its education department, the Commisssion provides services for children from pre-school age through college in public, private, and parochial schools. Instruction in braille and typewriting is provided to equip blind individuals with communication skills for college or vocations. During this period of education, psychological testing is carried out to assess adequately the student's intellectual level, his interests, and aptitudes.

The home-bound blind person is provided with instruction in diverse crafts as both a leisure outlet and also to enable the individual blind person to be self-sustaining to a degree. The sale of articles through its home industries division totals over $200,000 a year, with net income going directly to the blind worker.

Through the contract shop, employment is made available to blind persons to prepare them for competitive employment and to meet the standards and quality demanded by industry. The electric toothbrush you are using may be one of the many articles made, assembled, or repaired by a blind worker.

For the newly-blinded person, home services are provided, since expert counseling is a must during this period. The rehabilitation teacher introduces new techniques for everyday activities and gives lessons in braille and typewriting. The client's leisure hours are filled by listening to talking books or tapes with recordings of books, magazines, or music.

The Vocational Rehabilitation Department attempts to train and place capable blind persons in gainful employment. It also attempts to help the newly blinded person adjust to his handicap taking advantage of and utilizing his prior skills and experiences. A successfully rehabilitated blind person is self-reliant, able to cope with his handicaps, and able to take his place in community life. He regains his self-esteem, so necessary for personal happiness. Groups are invited to observe a diagnostic and pre-vocational program in action at the Agency's Vocational Rehabilitation Center in Newark.

The Eye Health Division provides:

(1) Eye examinations and treatments

(2) Hospital for eye care

(3) Mobile Eye Health Unit which goes to convalescent homes, homes for the aged, areas of disadvantaged, and camps for itinerant workers. Eye examinations are provided by the traveling ophthalmologist.

(4) Pre-school screening is provided in many localities so that amblyopia may be detected early. Early referral and treatment is part of this program.

(5) Eye Health: Each September the Commission and The Medical Society of New Jersey cosponsor "Eye Health" week, during which all persons over age 35 can go to screening centers at their local hospitals where an ophthalmologist is in attendance. Tests for glaucoma and other eye diseases are performed and persons found to have positive or suspicious results are referred to personal eye practitioner.

(6) Consultation services: Multi-disciplinary services are provided for the blind or visually impaired.

(7) Eye surgery is also provided and paid for within scale of Blue Shield for eligible clients.

Revision of Medical Staff Bylaws

A Simplified Approach

The following was prepared by Stanley Burrows, M.D., who is Chief Attending Pathologist and Chairman of the Bylaws Committee of the Medical Staff at The Cooper Hospital, Camden, New Jersey.

The bylaws of the medical staff establish the general guidelines for the practice of medicine at a hospital and the interrelationships between practitioners, the administrator, and the governing body. Changing concepts of adequate medical care and quality control of medical practice, together with more stringent interpretation by legal authorities have necessitated major changes in most hospital medical staff bylaws in the last few years. Some of these changes may be incorporated into existing bylaws by amendment. However, many changes are so extensive that most medical staff bylaws that were prepared more than two or three years ago must be completely rewritten.

The medical staff of The Cooper Hospital recognized the need for bylaws revision for several years, but the matter became more urgent after direct criticism from the Joint Commission on Accreditation of Hospitals. The Cooper Hospital is a general hospital of over 600 beds and has a medical staff of about 250 practitioners. The complete revision of the bylaws was accomplished relatively quickly and easily by establishing and following flow chart of action (see Figure). We hope that our experience in this matter will be of benefit to other hospitals that must revise their medical staff bylaws.

First Draft

One individual must take the responsibility for drafting the bylaws. He should be appointed as chairman of the bylaws committee and may choose two or more members of the medical staff for the bylaws committee. A long document cannot be prepared by a committee and it is best that a single individual have this responsibility, with the realization that the draft will be modified during its consideration by the medical staff.

Flow Chart of Action for the Preparation and Approval of Medical Staff Bylaws, Rules and Regulations.

Chairman, Bylaws Committee
Preparation of First Draft
↓
Initial Distribution to:

1. President of Staff
2. Chairman of Executive Committee
3. Chairman of Credentials Committee
4. Administrator
5. Hospital Counsel
6. Immediate Past-President of Staff
7. Members of Bylaws Committee

↓
Chairman, Bylaws Committee
Preparation of Selected Changes
to Proposed Bylaws
↓
Distribution to All Members
of Executive Committee
↓
Special Meeting of Executive
Committee for Review of
Proposed Bylaws
↓
Chairman, Bylaws Committee
Preparation of Draft of
All Changes Adopted By the
Executive Committee
↓
Approval at Next Regular Meeting
of Executive Committee
↓
Distribution to Entire
Medical Staff
↓
Consideration and Approval
at General Staff Meeting
↓
Consideration and Approval
by Governing Body

The draft should follow the format of "Guidelines for the Formulation of Medical Staff Bylaws, Rules, and Regulations," prepared by the Joint Commission on Accreditation of Hospitals. Some sections may be included almost verbatim, whereas other sections will require considerable modification to conform to local requirements and staff policies.

The formulation of rules and regulations should include all such rules and regulations adopted by the medical staff and the executive committee during the previous few years. Review of the minutes from such meetings can serve as a readily available source for this section, with format and amplification from the guidelines of the Joint Commission.

In addition, any deficiencies in the bylaws, rules, and regulations noted from the most recent survey of the hospital by the Joint Commission on Accreditation of Hospitals should be corrected in the proposed new bylaws, rules, and regulations.

Initial Distribution and Feed-Back

The first draft may have significant deficiencies. The initial distribution is intended to include several key figures on the medical staff and hospital management, as well as the hospital counsel, to provide modifications that will be necessary for later approval by the medical staff, hospital management, and the governing body. The early review and approval by these key figures will provide for a smoother process in the final enactment of the new bylaws.

Feed-back from initial distribution must be used in the preparation of selected changes to the first draft. The draftsman must carefully review all feed-back comments and select those that appear proper for modifications. The remainder of feed-back comments should be listed separately for later review by the executive committee.

Approval by the Executive Committee

Copies of the proposed bylaws with selected changes from initial feed-back and other suggestions are distributed to all members of the executive committee of the medical staff. Sufficient time must be permitted for all members to study the proposed bylaws so that their familiarity with them will avoid the need to read the bylaws verbatim at the formal executive committee meeting. Despite this, a special meeting of the executive committee is necessary to allow sufficient time for intelligent consideration of such a large and important document.

Proposed changes adopted by the executive committee are then prepared by the chairman of the bylaws committee and distributed to the members of the executive committee prior to their next regular meeting. The complete bylaws, including these proposed changes, may be approved by the executive committee at its next regular meeting.

Final Adoption

A second draft of the proposed bylaws, incorporating all changes adopted by the executive committee, is prepared by the chairman of the bylaws committee and copies are distributed to the entire medical staff at least 30 days before its next regular meeting. This permits sufficient time for review of the material to avoid the need to read the bylaws verbatim at the meeting. There has been opportunity for so much discussion and feed-back from influential members of the medical staff, department heads, and hospital management prior to this time, that approval by the general medical staff and then the governing body should be largely a formality.

Therapeutic Drug Information Center

The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center, which is located at the Valley Hospital in Ridgewood, is a project of the New Jersey Regional Medical Program. The Center serves as a source of intelligence on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions, and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor of Pharmacy and Director of Drug Information, Brooklyn College of Pharmacy, is Project Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College is pharmacologist consultant. The service is free, avail-

able Monday through Friday from 9 a.m. to 5 p.m.—telephone (201) 445-4900, extension 132. Below are three questions and answers handled by the Center recently.

1. Is hypertension a side effect of the "minipill?"

Norethindrione alone, the "minipill,"* in a dose of 0.35 mg per day is available as an oral contraceptive (Micronor,® Ortho; Nor-QD,® Syntex) but is less effective as a contraceptive than the estrogen-progestogen combinations.

One area of concern is the effect of oral contraceptives on blood pressure. A review of the literature reveals the incidence of hypertension from the combination products ranges from a very low figure to 15.5 per cent.[1] This rise in blood pressure is sometimes severe but is usually reversible after withdrawal of the drug. The mechanism for the blood pressure rise is uncertain but the "pill" has been shown to produce changes in the renin-angiotensin-aldosterone system which together with other sodium-retaining effects may be involved in causing blood pressure elevations.[2]

Data suggests that the estrogenic component of the combination is the main causative factor in observed changes in the renin-angiotensin system. While the progestogens may not be a factor in the renin substrate stimulation, this does not exclude the possibility that they participate in pressor reactions.[3]

The British Committee on Safety of Drugs and others have concluded that products containing no more than 0.05 mg of estrogen per tablet appear safer from the standpoint of vascular side effects than those which contain greater amounts of estrogen.[4]

Spellacy, *et al.*[5] conducted a study involving 415 women with normal blood pressure. They were given either individual estrogens, individual progestogens, or combination oral contraceptive products. In addition, a control group was similarly followed. The results showed that hypertension occurred with the use of the combination contraceptives, in the mestranol group, and in the ethinyl estradiol group (both mestranol and ethinyl estradiol are used as estrogen components of oral contraceptives). Blood pressure did not rise in the control group, the progestogen-treated group, or in those receiving conjugated estrogens. The study also revealed that the frequency of hypertension was significantly greater if the women had hypertension in a previous pregnancy.

In personal correspondence with Syntex, a statement was made that a rise in blood pressure has rarely been seen in patients on Nor-QD®; however, they do recommend blood pressure evaluations be performed in all patients receiving oral contraceptive medication.[6]

In conclusion, it appears that adverse effects of oral contraceptives on blood pressure are related to patient and steroid selection, and that rises in blood pressure associated with the "minipill" have rarely been seen.

References

[1]Weir R J, *et al:* Blood pressure in women after one year of oral contraception. *Lancet* 1:467, 1971

[2]Meyler L and Herxheimer A: Side effects of drugs, vol 7. *Excerpta Medica* Amsterdam 1972, p. 547-548

[3]Laragh J H: Oral contraceptive hypertension. *Postgrad Med* 52:78-105 (Sept), 1972

[4]Anon: Oral contraceptives and thromboembolism. *Med Let* 14:61-62 (Aug 18), 1972

[5]Spellacy W M: The effect of intrauterine devices, oral contraceptives, estrogens, and progestogens on blood pressure. *Am J Obst Gynecol* 112:912-919 (Apr), 1972

[6]Based on personal correspondence between Dr. Ben Z. Taber, Vice President Medical Affairs at Syntex and our staff.

*A second "minipill" has recently been made available containing 0.075 mg of the synthetic progestogen, norgestrel (Overette,® Wyeth).

2. Do you have any information concerning a new drug to treat levodopa-induced dyskinesias?

The appearance of abnormal involuntary movements in patients with Parkinson's disease who are receiving levodopa is considered a severe and potentially troublesome side effect of this treatment. Its incidence ranges from 49 to 55 percent. The abnormal movements generally are considered to be dose-related and often occur after prolonged treatment. Presently, the way to eliminate the abnormal movements is to reduce the optimal dosage of levodopa, which results in a sacrifice in the control of extrapyramidal symptoms[1].

The etiology of levodopa-induced dyskinesias is not completely understood, and it has been suggested that stimulation of the cholinergic system theoretically should alleviate dyskinesias.

Recently, Miller[2] treated 11 patients with deanol (Deaner®, Riker Laboratories) a drug which has been shown to cross the blood-brain barrier following oral administration and to be converted to acetylcholine intracerebrally.[3] (Deanol in a dosage range of 25 to 100 mg is presently being utilized as an adjunct in the treatment of behavioral problems and learning difficulties in school age children and has been employed in both children and adults, in treatment of chronic fatigue, neurasthenia, and mild depression.) In a dose of 500 to 900 mg per day, deanol completely eliminated the levodopa-induced dyskinesias in eight out of the eleven patients and resulted in improvement in one patient. Of the remaining two patients, one stopped the treatment because of a feeling of fatigue and the other exhibited no improvement. Improvement in those in whom the drug was beneficial began 10-14 days after initiation of treatment. In five patients treated successfully with deanol, placebo was substituted after four weeks and dyskinesias reappeared within 3 to 8 days.

In conclusion, this study suggests that deanol may be effective in combating levodopa-induced dyskinesias and further studies are needed to substantiate this significant finding.

References

[1]Tarsy D, Leopold N, and Sax D S: Physostigmine in choreiform movement disorders. *Neurology* 24:24-33 (Jan), 1974

[2]Miller E: Deanol in the treatment of levodopa-induced dyskinesias. *Neurology* 24:116-119 (Feb), 1974

[3]Anon: American hospital formulary service, American society of hospital pharmacists, Washington, D.C., 1973, 28:80

3. I recently was made aware that there is an interaction between chlorpromazine (Thorazine)® and ant-

acids. How significant is this and does it involve all antacids?

Recently, reports have appeared indicating that gel-type antacids, specifically those containing aluminum hydroxide, may interfere with the absorption of chlorpromazine* when administered concurrently.

Fann, *et al.*,[1] have reported a case in which a patient who was undergoing an acute psychotic break and who had his psychosis well controlled on chlorpromazine relapsed within three days after being placed on a regular regimen of antacid medication. When the antacid was discontinued the chlorpromazine appeared to be again clinically effective. Fann then studied six hospitalized psychiatric patients who were given liquid chlorpromazine orally alone and then concomitantly with a gel-antacid (Gelusil)®. Plasma levels of chlorpromazine were significantly lower after gel-type antacid-chlorpromazine combination than after chlorpromazine alone. Fann also indicated that brain homogenates from rats given labelled chlorpromazine with an antacid showed significantly lower levels of isotope as compared with those given labelled chlorpromazine without antacid.

A study by Forest, *et al.*,[2] was designed to determine the effect of aluminum hydroxide with magnesium hydroxide (Aludrox®) on urinary chlorpromazine excretion. The administration of chlorpromazine concomitantly with the antacid significantly reduced the chlorpromazine excretion rate. The authors indicate that the antacid acts as a physical absorbent when administered simultaneously with chlorpromazine, thus lowering chlorpromazine efficiency.

In conclusion, in those situations in which it is necessary to receive both chlorpromazine and an antacid, this interaction may be minimized by administering the antacid 1 hour before or 2 hours after the administration of chlorpromazine or substituting an ionic type antacid, i.e., calcium carbonate and gylcine, (Titralac)® for the gel-type anacid.

References

[1]Fann W E, *et al.*: Chlorpromazine: effects of antacids on its gastrointestinal absorption. *J Clin Pharmacol* 13:388-390 (Oct), 1973

[2]Forrest F M, *et al.*: Modification of chlorpromazine metabolism by some other drugs frequently administered to psychiatric patients. *Biol Psychiatry* 2:53-58 (Jan), 1972

*Although this interaction has been documented for chlorpromazine, other phenothiazine derivatives theoretically can be expected to behave similarly.

PATRONIZE

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CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

Shortly after the College of Medicine and Dentistry of New Jersey's New Jersey Medical School settled in Newark, in 1967, a group of medical students and their teachers devised a plan to reach the community with an outpatient program of ongoing preventive health care. They drew up a model for a family health care center that would be run by teams of medical students with back-up support from health professionals, including attending physicians, nutritionists, and social workers. To test the plan they formed a few teams and began caring for local families at Martland Hospital, the school's primary teaching hospital. It wasn't long before word about the low-cost, sometimes no-cost, project began to circulate and more families came to Martland to register with the program.

Following the progress of the fledgling project, the New Jersey Department of Health decided to lend its support and provided financial assistance for 10 student teams. More students volunteered for the project and additional teams were formed thanks to support from such private organizations as Prudential Insurance Company, Ciba-Geigy Foundation, Merck Company Foundation, and Schering Foundation.

Ciba also financed an outside evaluation of the center, which found it "a major expression" of the college's commitment to health care in Newark, providing "competent, much-needed medical care to several hundred Newark families each year. The study also lauded the operation for offering sizable educational benefits to student participants."

The center has served some 800 local families since 1972. A closer look at one of those families lends some insight into the nature of services provided.

The family of Simeon Henry—husband, wife and five sons—settled in East Orange a little

over a year ago, after leaving their home in the English-speaking province of Guyana, South America. They came in search of a brighter, easier way of life, and a better opportunity for educating their children. But, as so often happens, problems jolted their dreams. In their case it was health problems: a brain tumor and post-operative care for one son, a possible respiratory condition in another, and a variety of lesser ailments.

Mr. Henry discovered that these problems were not dealt with cheaply, and he sought help. He found it at the center after a neighbor told him of the project. Dr. Fred Smith, who was senior medical student of the team treating the Henrys before he was graduated this year, said that the family arrived at the center with a variety of medical problems, some of which required long-term treatment. Medical problems are not the only concern of the student teams. They get involved with social history as well and, wherever possible, try to better the family's situation in other areas.

"For instance," Dr. Smith said, "we found that the education of one of the Henry children was interrupted at an early age and we placed him in a remedial program." On other occasions, medical teams have arranged special activities for families, such as picnics and sporting events.

As the Henrys learned, today's Student Family Health Care Center is a blossoming endeavor with more than 200 students making up 30 teams supervised and supported by physicians, psychiatrists, dieticians, nurses, and social workers. Each team includes a senior, coordinator of team acitivities, two juniors, two sophomores, and a freshman, all participating in family care on a level commensurate with their education and skills. Supervisory physicians are available for consultation at all times and are accountable medically and legally for the patients. Students volunteer to work one night a week with their teams. They get no college credit but the practical experience has been called invaluable by the faculty.

"The program is an advancement in student-medical education," Dr. Allyn Kidwell, center director, reports, "because it gives students a chance to learn how to relate to a patient, take a medical history, and be a part of family health care at the earliest possible time. Many students don't get this kind of continuous patient contact until after graduation.

"We are looking to register health families at the center and then strive to keep them healthy."

The study financed by Ciba concurs. The center gives competent, much-needed medical care to several hundred Newark families each year. The care is accessible to patients, and is delivered for the most part to families who cannot afford a private doctor.

1974-1975

MEMBERSHIP DIRECTORY

Preparations for the new edition of the Membership Directory of The Medical Society of New Jersey are nearing completion and it is anticipated that copies will be mailed to each member in early October.

Interested individuals, institutions, or organizations may purchase copies ($14 each, plus 5% sales tax where applicable, payable in advance) by sending a request, with accompanying check, to the Membership Directory Office, MSNJ, attention of Mrs. Humphrey, P.O. Box 904, Trenton, New Jersey 08605.

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Communicable Disease Control Program of the New Jersey State Department of Health during May and June, 1974:

	1974 May	1973 May
Aseptic meningitis	11	3
Primary encephalitis	1	2
Hepatitis: Total	202	187
Infectious	75	155
Serum	29	32
Unspecified	98	0
Malaria: Total (Civilian)	1	1
Meningococcal meningitis (Civilian)	2	3
Mumps	87	199
German measles	86	808
Measles	1221	102
Salmonella	61	75
Shigella	82	48
Tuberculosis	118	
Syphilis-primary and secondary	70	
Gonorrhea	1241	

Note: Gonorrhea, syphilis, and tuberculosis are figures for the previous month.

	1974 June	1973 June
Aseptic meningitis	7	14
Primary encephalitis	3	2
Hepatitis: Total	243	148
Infectious	80	71
Serum	55	28
Unspecified	108	0
Meningococcal Meningitis (Civilian)	6	8
Mumps	90	75
German measles	95	12
Measles	713	188
Salmonella	80	60
Shingella	78	32

Lymphocytic Choriomeningitis

Lymphocytic choriomeningitis (LCM) is a rare disease caused by a virus which is pathogenic for wild or laboratory mice, hamsters, and guinea pigs. Infection is generally transmitted to man through inhalation or ingestion of infected dried animal urine or feces, or by being bitten by an infected animal which may not show signs of disease. This incubation period is usually from one to three weeks. The symptoms in man can range from a flu-like syndrome to a full-blown meningitis. If a spinal tap is performed, the cerebrospinal fluid is likely to have several hundred cells, predominantly lymphocytes, slightly elevated protein, and normal sugar.

In December, 1973, one of fourteen breeders supplying pet hamsters to a firm which distributes hamsters nationwide, released an unknown number of hamsters infected with lymphocytic choriomeningitis virus. Human cases of LCM were first traced to these infected hamsters in New York in February, 1974.

Eleven laboratory confirmed cases of LCM have been found in residents of New Jersey. These cases can be traced to association with five hamsters all of which were distributed by the company between December, 1973 and March, 1974. Infected hamsters were shown to infect several members and neighbors of the same household. Three of the hamsters were available for laboratory study and were positive for LCM by serologic testing. Three of the eleven cases had meningitis and were hospitalized. None of the cases was fatal. Seven of the cases had a flu-like illness and one, a two year old child, was asymptomatic. Six cases were adults: five were children.

The nationwide outbreak has been controlled by stopping the distribution of LCM infected hamsters. Asymptomatic infected hamsters may still be living in homes throughout the nation. Patients with symptoms of meningitis should be questioned about their association with pet hamsters.

Questions concerning specimens submitted to the New Jersey State Laboratory for the diagnosis of this rare disease or other central nervous system diseases, should be directed to the Division of Laboratories and Epidemiology, (609) 292-7300.

Physicians' Relief Fund

The Physicians' Relief Fund of The Medical Society of New Jersey is available to members of MSNJ in need of financial assistance in time of emergency or catastrophe. Applications are made through your county medical society—write or call the Secretary or the Executive Secretary for information.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

EMERGENCY ROOM—Jeffrey S. Menkes, M.D., 41 Morris Road, West Orange 07052. Yale 1972. Hospital or group. Available September 1974.

INTERNAL MEDICINE—Joseph G. Boak, M.D., 1455 Jericho Rd., Abington, Pennsylvania 19001. Pennsylvania 1970. Board certified. Subspecialty, cardiology. Group. Available.

Thomas J. Cuomo, Jr., M.D. 5405 Markview Lane, Richmond, Virginia 23234. Jefferson 1968. Board eligible. Subspecialty, cardiology. Group or partnership. Available June 1975.

Harry Seneca, M.D., 420 Park Place, Fort Lee 07024. Tulane 1943. Board certified. Subspecialty, gastroenterology, immunology. Group or partnership. Available.

Stephen Glouberman. M.D., 1403-A Washington Blvd., San Francisco 94129. SUNY (Downstate) 1966. Board eligible. Subspecialty, gastroenterology. Group or partnership. Available January 1975.

Manjit Singh, M.D., 1874 Pelham Parkway, South, Bronx, New York 10461. New Delhi 1966. Group or partnership. Available.

Syed A. Qaivam Jafri. M.D., 390 1st Avenue, Apt. 11-H, New York 10010. Liaquat (Pakistan) 1965. Board certified. Subspecialty, cardiology. Group, solo, hospital, teaching. Available December 1974.

Vincent T. Randazzo, M.D., 3719 Sebille Drive, Alexandria, Louisiana 71301. Jefferson 1973. Board certified. Group, partnership, or hospital. Available August 1975.

OBSTETRICS AND GYNECOLOGY—Richard Fox, M.D., 200 Carman Ave., Apt. 19-B, East Meadow, New York 11554. St. Louis 1970. Association or partnership. Available July 1975.

Whan Soon Chung, M.D., 104 Sundridge Dr., North Tonawanda, New York 14120. Yonsei (Korea) 1966. Board eligible. Solo, group, partnership. Available January 1975.

Hugo Cimber, M.D., Tower Mountain Drive, Bernardsville 07924. Zurich (Switzerland) 1954. Board certified. Group, partnership, or hospital. Available.

ORTHOPEDIC SURGERY—Kiran J. Dave, M.D., 27 Abner Court, Bridgeport, Connecticut 06606. Baroda (India) 1967. Board Eligible. Group or partnership. Available July 1974.

Richard G. Traiman, M.D., 210 Locust Street, Philadelphia 19101, Jefferson 1967. Board eligible. Solo. Available July 1974.

OTOLARYNGOLOGY—Bruce Selden, M.D., 7836 Highway 51 North, Millington, Tennessee 38053. Chicago Medical School 1967. Board certified. Group, partnership, or association. Available June 1975.

Nae H. Park, M.D., 515 West 59th Street, Apt. 5-N, New York 10019. Kyung Pook (Korea) 1966. Board eligible. Solo, partnership, group. Available July 1, 1975.

PATHOLOGY—Jose F. Sotomayor, M.D., 11615 Radford Lane, Houston, Texas 77072. San Marcos 1967. Board eligible. Group, associate, or institution. Available September 1974.

Satish C. Shah, M.D., 229-26 Kingsbury Avenue, Flushing, New York 11366. B.I. Medical (India) 1964. Board eligible. Solo, institution, group, or partnership. Available.

PEDIATRICS—Arvinda K. Dave, M.D., 27 Abner Court, Bridgeport, Connecticut 06606. Baroda (India) 1967. Board Eligible. Group or partnership. Available July 1974.

Victoria Toma-Baciu, M.D., 86-11 148th Street, Jamaica, New York 11435. Faculty of Medicin (Rumania) 1951. Associate, group, institutional, clinic. Available July 1974.

Jerry J. Ferlauto, M.D., 2210 Auburn St., Rockford, Illinois 61103. Bologna (Italy) 1971. Board eligible. Subspecialty, neonatology. Group, partnership, or hospital. Available January 1975.

Barton W. Kaplan, M.D., 4358 Millwood Circle, Liverpool, New York 13088. SUNY (Upstate) 1968. Board eligible. Group or association. Available June 1975.

John A. Niziol, M.D., 5831 Walnut Street, Apt. 2, Pittsburgh 15232. Maryland 1972. Board eligible. Group or partnership. Available June 1975.

SURGERY—P. I. Mathew, M.D., 97-15 Horace Harding Expressway, Rego Park, New York 11368. Trivandrum (India) 1965. Board certified. Group, solo, or partnership. Available.

Enrique A. Saenz, M.D., McDonald Army Hospital, Fort Eustis, Virginia 23604. Javeriana (Bogota, Colombia) 1962. Group or partnership. Available January 1975.

Wuk Kim, M.D., 900 Woodward Avenue, Pontiac, Michigan 48053. Pusan (Korea) 1966. Board eligible. Partnership (would include general practice). Available July 1975.

UROLOGY—Harinath Kumar, M.D., 26 Meadow St., Demarest 07627. Gandhi (India) 1963. Group, partnership, or solo. Available.

Roger Wolfert, M.D., 101-B Birch Circle, Elgin AFB, Florida 32542. SUNY (Downstate) 1968. Partnership or group. Available July 1975.

CLINICAL NOTES

Xeroradiography in Acute Epiglottitis

Wm. E. Mattey, M.D. and H. P. Yeager, M.D.*
Livingston

A six-year old female was admitted to Saint Barnabas Medical Center for the first time on May 21, 1973, in acute respiratory distress with fever and general listlessness. Two days prior to admission, the patient developed malaise and a temperature of 101 which rose to 105 in the ensuing 24 hours. Supportive treatment was started, but she responded poorly and developed difficulty in swallowing and sore throat. Her fluid intake was inadequate. On admission, the child improved slightly with oxygen therapy. Physical examination revealed an extremely apprehensive child with mild-to-severe dypsnea, oral respiration, and congested nasal mucosa. There was exudative tonsillitis and pharyngitis, thick, infected post-nasal mucous, and tender cervical glands.

Mirror laryngoscopy revealed the epiglottis to be extremely thick, red, and heavy. The arytenoids could not be fully seen. A portable xeroradiographic study of the neck, utilizing a lateral soft tissue technique revealed the "thumb" print sign of bulbous edema of the epiglottis (Figure 1) confirming the presence of acute epiglottitis. Examination of the chest was unremarkable. Preparation for a tracheostomy was begun and the anesthesia department was consulted. The child was then started on Vasonephrine[R] and Decadron[R] nebulization. A thirty-minute trial of this therapy was planned, to be followed by tracheostomy if needed. Within 15 minutes of the onset of the vaporization, the child responded and tracheostomy was not necessary. She continued to improve with the Vasonephrine[R] treatments along with systemic antibiotics and was discharged from the hospital on May 26, 1973. A follow-up xeroradiographic lateral soft tissue neck film, taken a month later, illustrated a normal epiglottis. (Figure 2)

Throat and nasal cultures grew out heavy amounts of Hemophilus influenza along with Alpha Hemolytic Strep and Neisseria. Blood culture was performed on admission and Hemophilus influenza Type B was cultured from her blood directly. Heterophile studies were unremarkable.

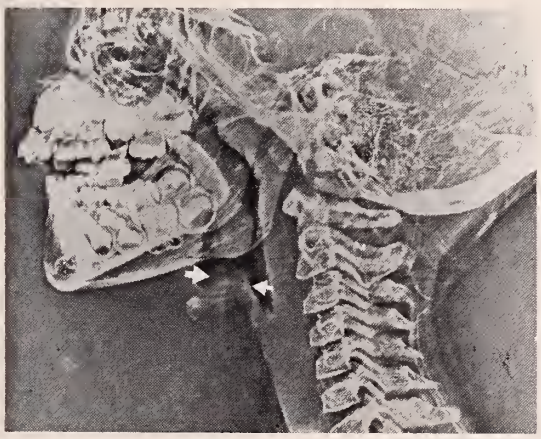

Figure 1—Xeroradiographic lateral portable neck film demonstrates massive inflammatory edema of the epiglottis in Hemophilus influenzae epiglottitis.

The final diagnosis was acute epiglottitis and bacteremia due to Hemophilus influenza (local and systemic).

Figure 2—One month follow-up xeroradiographic lateral neck film demonstrates the normal epiglottis.

Discussion

Acute obstructive supraglottic laryngitis in small children is frequently caused by Hemophilus influenzae Type B organisms.[2] However, staphylococcus, streptococcus, and pneumococci may produce the same clinical picture. Severe diffuse cellulitis of all the supraglottic structures may require tracheostomy within four hours after the onset of the first symptom.[5] Complaints are sore throat, increasing hoarseness, and high fever. Stridor is mainly inspiratory, with the child drooling, sitting up and leaning forward to facilitate air entrance past the edematous painful epiglottis.[1]

Treatment is with antibiotics after diagnosis is established by throat and nasal smears and cultures on admission. Tracheostomy is frequently necessary to prevent death from in-

*Dr. Mattey is Director, Department of Radiology and Dr. Yeager is Associate Attending in Otolaryngology at St. Barnabas Medical Center, Livingston

fectious respiratory obstruction. Acute laryngotracheobronchitis is easily differentiated from acute epiglottitis by the insidious onset, non-fulminating course, and less toxic symptoms.[5]

Xeroradiography of the neck for soft tissue detail, even with portable bedside technique, clearly illustrates the bulbous swelling of the markedly inflammed epiglottis. This study of the neck structures may distinguish other causes of intrinsic stridor (respiratory tract infection, neoplasm, anomalies, and trauma) from extrinsic stridor (congenital neck anomalies, extrinsic respiratory compression from aberrant structures, retropharyngeal abscess, and neoplasms).[4] Contrast studies, combined with xeroradiography, may be useful.

Summary

Acute epiglottitis is a fulminating cause of severe respiratory embarrassment which is frequently due to Hemophilus influenzae, Type B organisms. Cultures, antibiotics, and tracheostomy are often mandatory to prevent a fatal outcome. A xeroradiography lateral portable soft tissue neck film is helpful in establishing the diagnosis.

Bibliography

1. Apley J: The infant with stridor. *Arch Dis Child* 28:423, 1953

2. Caffey J: *Pediatric X-Ray Diagnosis* 6th ed, Chicago, 1972

3. Heller R M and Squire L F: (1973) *Exercise In Diagnostic Radiology,* Vol 5, *Pediatrics,* Philadelphia, 1973

4. Levine M I and Mascia A V: *Pulmonary Diseases and Anomalies of Infancy and Childhood,* New York, 1966

5. Miller A H: Acute epiglottis: acute obstructive supraglottic laryngitis in small children caused by hemophilus influenza, type B. *Tr Am Acad Opth* 53:519, 1949

MEDLINE Terminals

If your hospital wishes a MEDLINE-connected terminal installed, a request must be made through one of the eleven regional medical libraries that coordinate MEDLINE services. In New Jersey they are:

Northern New Jersey Region
New York Academy of Medicine Library
2 East 103rd Street
New York, New York 10029

Mid-Eastern Region
Library of the College of Physicians
19 South 22nd Street
Philadelphia, Pa. 19103.

MEDLINE and MEDLARS are presently available to Fellows of the Academy of Medicine of New Jersey through the Library of the College of Medicine and Dentistry of New Jersey (201-456-4581).

PATRONIZE OUR ADVERTISERS

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LETTERS TO THE JOURNAL

Posthumous Plaudits

May 21, 1974

Sir:

I do not know who HAD is but he should know how much I enjoyed (liked? loved?) his Editorial on "English: The Number One Language of Medicine."

I believe that those who have learned English as a second or third language are one or two up on the native American who knows only his mother's tongue. Goethe said: "Der Mann der nur seine Sprache kennt, kennt keine." As with the only child, "Eins ist keins."

I have no trouble at all with "to like" or "to love" in Spanish. I am likely to get "No quiere" or "No me gusta" from a Señorita to my proposal for a stroll in the moonlight unless I have first whispered tenderly "Yo la ama."

The German "Ich hab's gern" can pass for "I like it" when I am talking about things. There are locutions where cognates fail, but I can get around having another male mistake my intentions because my androgen level is too high for me to say "Ich liebe Dich" to a man whom I like, even a lot.

As for Editor Bhatia of the Delhi Times, he gloats amiss. India got "rid" of the British (as did the American Colonies) not so much because of "the effective use of the English language" but because of the tradition for justice and liberty in English jurisprudence and the writers he mentions. After all, Ghandi was a lawyer trained in England but he also knew Thoreau's "Civil Disobedience" which would be as potent in Urdu as in English but only an Englishman or American could write it.

Good thing for Bhatia that India inherited at least the English language if not its spirit otherwise his paper would have to be published in his 39 official native languages.

(Signed) Nicholas G. Demy, M.D.

Editor's Note: H.A.D. was, of course, Henry A. Davidson, the late esteemed Editor-in-Chief of *The Journal*. Unfortunately, we have almost exhausted the legacy of Doctor Davidson's editorials prepared prior to his death. A.K.

Nebulization of Lecithin for RDS: Question

April 24, 1974

Dear Doctor Krosnick:

It has been demonstrated that the lungs produce both sphingomyelin and lecithin as the principal surfactants prior to the 34th week of gestation. After this, the syntheses of lecithin increases rapidly and, as the proportion of lecithin to sphingomyelin increases, there is a decreased incidence of clinical hyaline membrane disease. The prenatal determination of the L-S ratio appears to be helpful in evaluating fetal pulmonary maturity.*

Might not this knowledge be helpful therapeutically? Could lecithin be nebulized into the isolette of the premature infant therapeutically (with oxygen in the presence of respiratory distress) or prophylactically? The purpose would be the simple mechanical one of coating the alveolar surfaces with surfactant to decrease the surface tension and thus reverse or prevent alveolar collapse.

Careful controlled studies first on immature animals and then on infants might be initiated at one or more of the larger medical centers.

(Signed) Bartholomew A. Ruggieri, M.D.

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* Rosenfeld C R and Eichenwald H F: The L-S ratio, its use in the prediction of respiratory maturity in infants. *JAMA* 227:619 (Feb. 11) 1974.

—and Answer

June 20, 1974

Dear Doctor Krosnick:

Thank you for the opportunity to respond to the thought-provoking question of Dr. Ruggieri. Respiratory distress syndrome accounts for approximately 25,000 neonatal deaths per year in the United States. At present there is no unified theory as to etiology. A primary deficiency or alteration in pulmonary surfactant coupled with alveolar hypoperfusion secondary to hypoxia are two factors that explain many of the clinical symptoms of RDS. Adequate perfusion of the lungs is required for surfactant production.

Aerosols with commercial preparations of lecithin have been utilized in an attempt to arrest the progressive course of the disease in newborns. On occasion, lung compliance has increased following treatment but no effective change in pulmonary gaseous exchange has resulted. In addition, tracheal enzymes would probably digest nebulized lecithin. It is difficult to reach the atalectatic portion of the lung and this would be the area which would benefit most. Having reached the alveoli, there is no evidence that surfactant lying free in the sac exerts significant surface-tension lowering activity. Normally surfactant is synthesized in the lining layer of the alveoli and then extruded onto the surface of this layer for its action to be effective. On the whole, experience with commercial lecithin preparations has been discouraging.

There is an alternative approach to management of RDS that often accomplishes the same result that nebulized surfactant hopefully would accomplish. If portions of the lung can be prevented from becoming atalectatic or can be re-expanded once they have collapsed, perfusion of these segments improve and native surfactant will be produced. This is the basis for continuous positive airway pressure (CPAP). In addition, micro-enzyme inducers of surfactant are being investigated for use in the mother prior to delivery.

(Signed) James P. Thompson, M.D.

Allergy Testing and Vaccine Preparation

May 24, 1974

Dear Doctor Krosnick:

A number of laboratories in New Jersey have canvassed physicians concerning allergy testing and preparation of allergy materials (extracts and vaccines). They claim to be qualified to perform testing, and to provide the physician with the test results and appropriate treatment preparations to be administered according to a standardized "cook-book" schedule.

The New Jersey Allergy Society has been informed of the following:

1. ". . . if allergy testing is being performed using the scratch or needle technique, this must be done by a physician licensed to practice medicine and surgery in this State." (A. J. Schuster, Executive Secretary, New Jersey State Board of Medical Examiners)

2. "Reference is made to your inquiry of May 7 concerning the need for a registered pharmacist to prepare the extracts of materials to be used in an allergy laboratory for skin testing. The Board feels that it would be necessary to use a Registered Pharmacist to prepare these materials." (Paul A. Pumpian, Secretary, New Jersey Board of Pharmacy)

The allergic patients who are referred to such laboratories are not receiving the type of high-quality medical care to which they are entitled. This is a disservice to these patients. The diagnosis of allergic disease is primarily made by history and physical examination. Allergy skin testing, properly done, is just an additional adjunctive source of information. Prescribing of proper dosage of individual treatment with antigens for the individual patient is a function of a properly trained physician, not a technician or laboratory aide.

As Chairman of the Legal Committee of the New Jersey Allergy Society, I feel it is appropriate and important to advise the members of The Medical Society of New Jersey of these facts.

(Signed) Arthur A. Goldfarb, M.D.

Comment on Psoriasis Treatment

June 10, 1974

Dear Doctor Krosnick:

Your efforts, and those of the Publication Committee, to improve *The Journal* and expand its scope to better serve the members of MSNJ are to be commended and encouraged.

However, in my opinion, you render a disservice and lower the scientific caliber of our State publication by including in *The Journal,* May 1974, Vol. 71, No. 5, p. 412, a so-called report of two cases of psoriasis treated with phenformin hydrochloride.

The paucity of the "report," and its complete lack of a single redeeming scientific observation, make it unworthy of publication in any reputable medical publication. In addition, the letters published in *The Journal,* June 1974, Vol. 71, No. 6, p. 506, are completely inane and accomplish no useful purpose.

Submission of clinical observations by our members should be encouraged but care must be taken to insure their scientific worth and accuracy.

(Signed) Emanuel M. Satulsky, M.D.

ANNOUNCEMENTS

Diagnostic Ultrasound in Pediatrics

On September 5 and 6, 1974 The Johns Hopkins Hospital will present a comprehensive program on the value of ultrasound as applied to pediatrics. Both practical and theoretical considerations which apply to the pediatric age group will be stressed. Fee is $150—residents, $100. Details may be obtained from Roger C. Sanders, M.D., Assistant Professor of Radiology, The Johns Hopkins Hospital, Baltimore, Maryland 21205.

American College of Physicians Graduate Courses

The American College of Physicians has announced the following graduate courses for internists:

Endocrinology and Metabolism—September 11-13, Indianapolis—cosponsored by Indiana University School of Medicine. A review for practicing internists and with emphasis on clinical relevance and areas in which knowledge is growing rapidly; diabetes and thyroid disease will be discussed.

Gastroenterology—September 16-18, Rochester, Minnesota—cosponsored by Mayo Clinic. A review of newer concepts in the pathogenesis, diagnosis, and treatment of selected gastrointestinal diseases; case histories will be presented.

Emergency Room Medicine—September 16-18, Arlington Heights, Illinois—cosponsored by Loyola University Stritch School of Medicine. Lectures and workshops in shock and respiratory care; review of pathophysiology and current treatments; social and economic problems in the emergency room.

Gastrointestinal Disease—September 30-October 3, Philadelphia—co-sponsored by University of Pennsylvania School of Medicine. Lectures and workshops on pathophysiology, diagnostic approach, and therapeutic rationale for major gastrointestinal diseases; case histories will be presented.

Pulmonary Disease—September 30-October 4, Philadelphia—cosponsored by the University of Pennsylvania School of Medicine. Aimed at internists and pulmonary disease specialists who diagnose and treat respiratory disease; workshops and participant interaction with faculty.

For information and registration, please communicate with the Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, 19104.

Pulmonary Disease Lectures

The Veterans Administration Hospital in East Orange and the New Jersey Medical School, CMDNJ are cosponsors of a 1974-1975 series of lectures in pulmonary diseases, to be held on Wednesdays at 11:30 a.m. at the Veterans Administration Hospital, East Orange, on the dates indicated.

September 18	Patient with Diminished Resistance to Pulmonary Infection
October 16	Aspiration Pneumonia and Lung Abscess
November 20	Histoplasmosis
December 18	Emergency Pulmonary Care
January 15	Rifampin, Tuberculin
February 19	Chemical Control of Respiration
March 19	Cor Pulmonale
April 16	Infectiousness of Tuberculosis before and after Chemotherapy
May 14	Respiratory Failure

Course on Flexible Fiberoptic Bronchoscopy

The American College of Chest Physicians, in cooperation with the American Lung Association, will offer a graduate course on flexible fiberoptic bronchoscopy on September 19 and 20, 1974 at the Nassau County Medical Center in East Meadow, New York. The program will include diagnostic and therapeutic instructions in the use of the flexible fiberoptic bronchoscope, with a review of fundamental and advanced techniques for the practicing physician. Workshops will be held at participating hospitals. Twelve credit hours will be given toward the AMA Physician's Recognition Award. Tuition is $100 for members of the College, $125 for non-members, and $55 for interns and residents. Reservations can be made by writing to Oscar Cunanan, M.D., 405 Ostrander Avenue, Riverhead, New York 11901, or to the American College of Chest Physicians, 112 East Chestnut Street, Chicago 60611.

American Academy of Family Physicians

The 26th annual convention of the American Academy of Family Physicians will be held from October 14 to 17, 1974, in Los Angeles, California. Headquarters will be the Los Angeles Hilton, and the scientific assembly will be held at the convention center. Prior to the opening of the scientific program, the Congress of Delegates will convene on October 12. Registration fee is $15 for Academy members and $25 for non-member physicians.

Theme of the scientific assembly is "Care with Caring," with emphasis on treating the whole person within the context of his or her family and environment—caring *about* as well as *for* the patient.

Interesting events have been planned for the wives of physicians attending, and social activities for all have been arranged for the evenings. Details of the scientific programs and information on hotel reservations are available from the Academy at 1740 West 92nd Street, Kansas City, Missouri 64114.

Seminar on Head and Neck Tumors

On October 17, 18, and 19, 1974, the W. Franklin Keim Memorial Seminar will be held at Newark Eye and Ear Infirmary. The subject is "Pathology and Surgery of Head and Neck Tumors," and the presentations will systematically cover the various fields of the head and neck. A well-known faculty has been engaged. For details and information on registration, please write to Ki Hyun Han, M.D., Director, Department of Otolaryngology, United Hospitals Medical Center, 15 South Ninth Street, Newark 07107.

American College of Surgeons Congress

From October 21 to 25, 1974, in Miami Beach, Florida, the American College of Surgeons will hold its 60th annual clinical congress. Featured will be 17 postgraduate courses (hour-for-hour credit, category I), progress reports on more than 260 research programs, panel discussions, telecasts of operations, films scientific and industrial exhibits, and major addresses by the president of the

College and eminent guest speakers. Registration is free to Fellows, initiates, candidates, and surgical residents: the fee for non-Fellows is $90. There is a charge for registration in any of the postgraduate courses. For further information, please write to Edwin W. Gerrish, M.D., Assistant Director, Assembly, American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

Mental Health Seminar at Guadaloupe

From November 16 to 23, 1974, the Mental Health Sciences Department of Hahnemann Medical College and Hospital will sponsor a seminar at Fort Royal on Guadaloupe. Topics to be covered are human sexuality, borderline personality, emotional problems in medical practice, social psychiatry, and transcultural psychiatry. AMA Category I credit will be given for attendance. For information about the program and available "package" accommodations, please write to Richard A. Newman, M.D., Hahnemann Department of Mental Health Sciences, 230 North Broad Street, Philadelphia, Pennsylvania 19102, or telephone Ms. Carolyn Goldman, Post Graduate Education Coordinator at the College—(215) LO 7-3139.

Graduate Courses in Maternal and Child Health

The Maternal and Child Health Program of the University of California School of Public Health at Berkeley announces graduate courses leading to a Master of Public Health degree for pediatricians, obstetricians, and other physicians interested in the maternal and child health field. There are nine-month programs in maternal and child health, day care and the preschool child, health of school-age children, and family planning. Twenty-one month programs are offered in care of handicapped children, comprehensive health care, and perinatology. Tax-exempt fellowships are available (tuition and fees, support for trainee and dependents) and applications are now being accepted for the group entering September, 1975. Please write to H. M. Wallace, M.D., School of Public Health, University of California, Berkeley, California 94720.

MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

1974

Aug.

7 **Clinical Endocrinology**
21 3:30 p.m.—Martland Hospital, Newark
28 or VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

7 **Neuroscience (Distinguished Lecture Series)**
14 10:30-11:30 a.m.—VA Hospital, East Orange
21 *(Sponsored by CMDNJ, New Jersey Medical*
28 *School and Academy of Medicine)*

8 **Clinical Nephrology**
15 4-5 p.m.—Martland Hospital, Newark
22 *(Sponsored by CMDNJ, New Jersey Medical*
29 *School and Academy of Medicine)*

10 **Orthopedic Surgery**
17 8:30 a.m.—Martland Hospital, Newark
24 *(Sponsored by CMDNJ, New Jersey Medical*
31 *School and Academy of Medicine)*

21 **Workshop in Neurology**
7-9 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

Sept.

4 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

4 **Clinical Endocrinology**
11 3:30 p.m.—Martland Hospital, Newark Beth
18 Israel, and VA Hospital, East Orange (varies)
25 *(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)*

7 **Orthopedic Surgery**
14 8:30 a.m.—Martland Hospital, Newark
21 *(Sponsored by CMDNJ, New Jersey Medical*
28 *School and Academy of Medicine)*

10 **Renal Failure**
10 a.m.—North Hudson Hospital, Weehawken
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

13- **Cardiovascular Care Conference**
15 Haddon Hall, Atlantic City
(Sponsored by American Heart Association and Academy of Medicine)

18 **Renal Failure**
6 p.m.—Bridgeton Hospital, Bridgeton
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

19- **Electrocardiography Workshop**
22 Cherry Hill Inn, Cherry Hill
(Sponsored by AAFP)

24 **Renal Failure**
1 p.m.—Trenton Psychiatric Hospital, Trenton
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

25 **Plasma Lipoproteins and Disease**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

28 **Renal Failure**
9 a.m.—South Elizabeth Hospital, South Elizabeth
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

Oct.

2 **Endocrine Emergencies**
9 **Metabolic Acidosis and Related States**
16 **Thyroid Problems in Practice**
23 **Sexual Dysfunction**
30 **Neonatal Medicine**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

4-6 **Cancer in Childhood and Adolescence**
Playboy Club, Great Gorge
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

4 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

5 **Orthopedic Surgery**
12 8:30 a.m.—Martland Hospital, Newark
19 *(Sponsored by CMDNJ, New Jersey Medical*
26 *School and Academy of Medicine)*

9 **Psychodynamics and Treatment of Male Homosexuality**
8-10 p.m.—Englewood Hospital, Englewood
(Sponsored by Academy of Psychoanalysis of New Jersey and Academy of Medicine)

11- **Annual Convention—AAFP**
14 Los Angeles, California

15- **Review of Obstetrics**
18 Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School)

15 **Renal Failure**
1 p.m.—Ancora Psychiatric Hospital, Hammonton
(Sponsored by Nephrology Society of New Jersey and Regional Medical Program)

16 **Renal Failure**
9:30 a.m.—Bergen Pines Hospital, Paramus
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

16 **Renal Failure**
10 a.m.—St. James Hospital, Newark
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

23 **Rheumatic Diseases Workshop**
9 a.m.-3 p.m.—Rutgers Medical School, Piscataway
(Sponsored by New Jersey Rheumatism Association and AAFP)

Nov.

2 **Orthopedic Surgery**
9 8:30 a.m.—Martland Hospital, Newark
16 *(Sponsored by CMDNJ, New Jersey Medical*
23 *School and Academy of Medicine)*
30

6 **Clinical Endocrinology**
13 3:30 p.m.—Martland Hospital, Newark
20 *(Sponsored by CMDNJ, New Jersey Medical*
27 *School and Academy of Medicine)*

6 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, Academy of Medicine)

6 **Early Complications of Pregnancy**
13 **Hypothalamic Releasing Factors**
20 **Chemotherapy of Cancer**
27 **Disorders of Lower Esophagus**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

13 **Regional Meeting, American College of Physicians**
Rutgers Medical School, Piscataway

16 **Diabetes Today and Tomorrow**
9:30 a.m.-5 p.m.—St. Michael's Medical Center, Newark
(Sponsored by N.J. Diabetes Assn. and AAFP)

Dec.

4 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

4 **Clinical Endocrinology**
11 3:30 p.m.—Martland Hospital, Newark Beth Israel,
18 and VA Hospital, East Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

4 **Office Proctology**
11 **Androgen and Virilizing Syndromes**
18 **Mineralocorticoid Hypertension**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

7 **Annual Meeting, New Jersey Chapter, ACS**
Morristown Memorial Hospital, Morristown

1975
Jan.

4 **Orthopedic Surgery**
11 8:30 a.m.—Martland Hospital, Newark
18 *(Sponsored by CMDNJ, New Jersey Medical*
25 *School, and Academy of Medicine)*

7 **Renal Failure**
8 p.m.—Paul Kimball Hospital, Lakewood
(Sponsored by Paul Kimball Hospital and Academy of Medicine of New Jersey)

8 **Drug Management of Coronary Arterial Disease**
15 **Portal Hypertension**
22 **Inflammatory Bowel Disease**
29 **Common Disease of Travelers**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

8 **Clinical Endocrinology**
15 3:30 p.m.—Martland Hospital, Newark Beth Israel,
22 and VA Hospital, East Orange (varies)
29 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

10 **Portal Hypertension**
12 noon-4:30 p.m.—Hamilton Hospital, Trenton
(Sponsored by Hamilton Hospital)

Feb.

1 **Orthopedic Surgery**
8 8:30 a.m.—Martland Hospital, Newark
15 *(Sponsored by CMDNJ, New Jersey Medical*
22 *School, and Academy of Medicine)*

5 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

5 **Clinical Endocrinology**
12 3:30 p.m.—Martland Hospital, Newark Beth Israel,
19 and VA Hospital, East Orange (varies)
26 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

5 **Common Protozoal and Fungal Infections**
12 **Future of Allergy**
19 **Hemostasis**
26 **Hypercalcemia and Hyperparathyroidism**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

Mar.

1 **Orthopedic Surgery**
8 8:30 a.m.—Martland Hospital, Newark
15 *(Sponsored by CMDNJ, New Jersey Medical*
22 *School, and Academy of Medicine)*
29

5 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 **Clinical Endocrinology**
12 3:30 p.m.—Martland Hospital, Newark Beth
19 Israel, and VA Hospital, East Orange (varies)
26 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

5 **Heart Block and Syncope**
12 **Renal Failure**
19 **Resuscitation in Shock and Trauma**
26 **Office Urology**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

Apr.

2 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

2 **Common Errors in Practice**
9 **Medical Hypnosis**
16 **Functional Diseases**
23 **Interaction of Drugs Used in Cardiac Disease**
30 **Stroke Rehabilitation**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

2 **Clinical Endocrinology**
9 3:30 p.m.—Martland Hospital, Newark Beth Israel,
16 and VA Hospital, East Orange (varies)
23 *(Sponsored by CMDNJ, New Jersey Medical*
30 *School, and Academy of Medicine)*

5 **Orthopedic Surgery**
12 8:30 a.m.—Martland Hospital, Newark
19 *(Sponsored by CMDNJ, New Jersey Medical*
26 *School, and Academy of Medicine)*

May

3 **Orthopedic Surgery**
10 8:30 a.m.—Martland Hospital, Newark
17 *(Sponsored by CMDNJ, New Jersey Medical*
24 *School, and Academy of Medicine)*

7 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 **Clinical Endocrinology**
14 3:30 p.m.—Martland Hospital, Newark Beth Israel
21 Medical Center, and VA Hospital, East Orange
28 (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 **Minor Surgery in Office Practice**
14 **Learning Disabilities**
21 **Nutrition of the Aged**
28 **Emotional Aspects of Common Medical Problems**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital

June

4 **Clinical Endocrinology**
3:30 p.m.—Martland Hospital, Newark Beth Israel Medical Center, and VA Hospital, East Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 **Orthopedic Surgery**
8:30 a.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

OBITUARIES

Dr. Frederick A. Cracco

On April 3, 1974, Frederick A. Cracco, M.D., a senior member of our Hudson County component, died following a brief illness. Born in Italy in 1897 and a graduate of Cornell University Medical School in 1924, Dr. Cracco practiced general surgery in Union City all of his professional life, until retirement to Princeton in 1971. He had been on the surgical staff at Christ Hospital in Jersey City and at North Hudson Hospital in Weehawken. Dr. Cracco was a laureate of MSNJ's Golden Merit Award at our Annual Meeting last May.

Dr. William B. Ein

Word has just been received of the death, on April 4, 1974, of one of Essex County's emeritus members, William B. Ein, M.D., of East Orange. Born at the turn of the century, Dr. Ein was graduated from McGill University Medical College in 1923. He was an orthopedic surgeon, a diplomate in his specialty, and senior attending in that department at Newark Beth Israel Hospital, before his retirement in 1969. In earlier years he had also held staff appointments at Martland, Crippled Children's, St. James, and St. Barnabas Hospitals. In addition to being board certified, Dr. Ein was a Fellow of the American College of Surgeons, the International College of Surgeons, and the American Academy of Orthopedic Surgeons, and a member of the New Jersey Orthopaedic Society, and the Association of Military Surgeons of the United States. During World War II, Dr. Ein served his country as a medical officer in the AUS. He was a 1973 laureate of MSNJ's Golden Merit Award.

Dr. David Feinberg

On June 16, 1974, David D. Feinberg, M.D., a retired internist from Trenton, died at Helene Fuld Medical Center there. A graduate of Hahnemann Medical College (Chicago) in 1924, Dr. Feinberg practiced in Hudson County prior to moving to Trenton in 1956 to accept a position as full-time industrial physician for the Pennsylvania Railroad. He had been a captain in the medical department of the AUS during World War II. Dr. Feinberg was 73 years old at the time of his death.

Dr. Carlos C. Gumucio

At the untimely age of 48, Carlos C. Gumucio, M.D., who had been elected last fall to membership in the Essex County Medical Society, died on April 27, 1974. Dr. Gumucio earned his M.D. degree at São Paulo University in Brazil in 1950 and took graduate work in pathology at Bethany Medical Center in Kansas City, Louisville University Medical School, and Northwestern University Medical School. He was board certified in his chosen specialty

(both anatomic and clinical) and was a member of the faculty at the New Jersey Medical School, CMDNJ, as well as pathologist at the Veterans Administration Hospital in East Orange. He had been in general practice in Brazil and Bolivia before coming to the United States in 1956. He served five years with the medical corps of the AUS, retiring with the rank of lieutenant colonel.

Dr. Harry Hansen

One of Union County's well-known pathologists, Harry Hansen, M.D., of Plainfield, died on June 14, 1974, at the age of 66. A graduate of Columbia University's College of Physicians and Surgeons, class of 1933, Dr. Hansen was board certified in clinical pathology and was chief pathologist at Muhlenberg Hospital in Plainfield for 25 years. He also operated his own clinical laboratory in Plainfield, and during the 1950's was assistant medical examiner for Union County. He was a Fellow of the American College of Pathology and a member of the American Society of Clinical Pathologists.

Dr. William J. Harman

At the grand age of 95, one of Mercer County's renowned obstetricians, William J. Harman, M.D., died on June 4, 1974. A graduate of Jefferson Medical College in 1900, Dr. Harman was attending obstetrician and, for 17 years, chief of that department at St. Francis Hospital, Trenton, until retirement in 1943, when he was succeeded in that position by his son, the late Dr. J. Reginald Harman (obituary, *JMSNJ*, vol. 70, no. 10, October 1973). He was an emeritus member of the Mercer County Medical Society and had received MSNJ's Golden Merit Award in 1957.

Dr. Milton Jabush

Milton Jabush, M.D., one of our members from Ocean County, died tragically in a plane accident on May 4, 1974. Dr. Jabush was piloting a private plane en route to Florida when engine trouble developed, and he crashed while attempting an emergency landing in Myrtle Beach, South Carolina. Born in 1923, he was graduated from the University of Tennessee Medical School in 1953 and had been a family practitioner in the Lakewood area for twenty years. Dr. Jabush was certified by the American Board of Family Practice and a member of the American Academy of Family Practice. He was on the staff at the Paul Kimball Hospital in Lakewood and had been school physician in Jackson Township.

Dr. J. Stauffer Lehman

On June 11, 1974, J. Stauffer Lehman, M.D., radiologist at Shore Memorial Hospital in Somers Point, died at his home. A transfer to the Cape May County Medical Society from the Philadelphia County Medical Society in 1971, Dr. Lehman was Professor and Chairman of the Department of Radiology at Hahnemann Medical College, Philadelphia, until retirement in 1970, having advanced from his original appointment as clinical instructor in that department in 1936. A 1931 graduate of Hahnemann, he did postgraduate work in radiology there, at Johns Hopkins University Hospital in Baltimore, and at Duke University Hospital in Durham, North Carolina. He was board certified in that specialty and was a Fellow of the American College of Radiology and a member of the American Roentgen Ray Society, the Radiological Society of North America, the American Institute of Ultrasound in Medicine, and the American Radium Society.

Dr. Anthony Lettiere

One of Mercer County's senior surgeons, Anthony J. Lettiere, M.D., died on May 17. Born in 1902, he was a graduate of Georgetown Medical School, class of 1926, and was a Fellow of the American College of Surgeons and a diplomate of the American Board of Surgery. Dr. Lettiere was a member of the surgical staff at St. Francis Hospital in Trenton, becoming director of that department and president of the medical staff. He was also director of surgery at the newly established Hamilton Hospital in Trenton. He was

regional director of the International College of Surgeons and associate professor of surgical anatomy at the University of Pennsylvania Graduate School of Medicine, where he was involved in research as well as teaching. Dr. Lettiere was a member of the American Urological Association, the American Society of Abdominal Surgeons, and the New Jersey Society of Surgeons.

Dr. Ralph A. Pattyson

Ralph A. Pattyson, M.D., a member of our Essex County component, died on April 25, 1974 in New York University Hospital. Born in Buffalo in 1902, Dr. Pattyson received his medical degree from Syracuse University Medical School in 1930, and took residencies in obstetrics and gynecology at Louisville University, New York Postgraduate Hospital, and Long Island College Hospital. He practiced his chosen specialty in the Oranges for 32 years and was on the staff at Orange Memorial Hospital. Since retirement in 1968, Dr. Pattyson moved to Newton and became a member of the emergency room staff at Newton Memorial Hospital. He was a Fellow of the American College of Surgeons and a member of the American College of Emergency Physicians, and had served during World War II as a Commander in the US Navy.

Dr. Herbert A. Schulte

One of Essex County's emeritus members, Herbert A. Schulte, M.D., died on May 7, 1974. Dr. Schulte received his M.D. degree from Columbia University College of Physicians and Surgeons in 1919 and practiced general surgery in the Newark area until retirement in 1966 to Denville. He had been a member of the staff at Martland and at Presbyterian Hospitals in Newark and at St. Barnabas Hospital in Livingston. He was a Fellow of the American College of Surgeons and a member of the prestigious New Jersey Society of Surgeons. Dr. Schulte was a recipient of MSNJ's Golden Merit Award in 1969.

Dr. Herbert H. Whigham, Jr.

At the untimely age of 57, Herbert H. Whigham, Jr., of Newark, died at his home on May 2, 1974. A graduate of Meharry Medical College in 1942, Dr. Whigham came to East Orange after internship and was a general practitioner there and in Montclair before moving to Newark in 1970. He did graduate work at Post Graduate, Mt. Sinai, and Bellevue Hospitals in New York, and served as a medical officer in the Army of the United States from 1943 to 1946. Dr. Whigham was on the staff at East Orange General, Orange Memorial, and St. Mary's Hospitals in Orange.

BOOK REVIEWS

The Soft Food Cookbook. Anne S. Chamberlain, New York, Doubleaday, 1973. Pp 130. ($5.95)

When a soft or semi-soft diet is prescribed and must be followed for an extended period of time, the regimen can be monotonous and unappetizing for the patient and an additional, tedious chore for a busy housewife. *The Soft Food Cookbook* is a collection of Anne S. Chamberlain's recipes which she used to feed her family and her invalid husband during his four-year illness.

Without a formal background in foods and nutrition, Ms. Chamberlain has applied the principles of basic nutrition: serving good nutritious food to meet the patient's needs in such a fashion that the food is appetizing, offers a variety of taste experiences, and is served in an appealing manner which both stimulates the appetite and keeps the patient in good spirits. Through "trial and error" Ms. Chamberlain has compiled eighty-three recipes which include meat, fish, poultry, vegetables, fruits, and dairy products. The semi-soft menus can be enjoyed by the whole family and when necessary there is advice on how to blenderize the menus for patients who have difficulty chewing and swallowing. To keep the family life-style as normal as possible, suggestions are given for menus for outings, what to do when visiting friends, and what to take along when traveling and on vacations.

The Soft Food Cookbook can be a helpful aid to anyone who is caring for a patient who has chewing and swallowing difficulties whether it be from a tonsillectomy, oral surgery, or a long-term illness.

Carol R. Blair

Current Pediatric Diagnosis and Treatment. C. Henry Kempe, M.D., Henry K. Silver, M.D., and Donough O'Brien, M.D. Los Altos, California, Lange, 1974. Pp. 1020. (Softback $12)

For the third time in a row the contingent of writers from the University of Colorado Medical School, with the help of a few others, have come up with a winner. The third edition is an excellent reference for the student, house staff, and the practicing pediatrician. The soft cover makes for a "battered textbook" but the cost is small in this inflationary era. The material is up to date and flows smoothly, even though more than fifty contributors took part in the writing.

The chapter on ambulatory pediatrics is most informative, and the eight-page well-child flow sheet (which is superior to many of the forms commercially available) used in the University of Colorado Pediatric Clinic provides a complete history and system review, supplied by the parent. It can be used to good advantage in any pediatric practice, clinic or private. The section on disorders of the immune mechanisms is short but meaty. The chapter on drug therapy lists the drugs most frequently used with the pediatric dosages. The information on interpretation of biochemical values is handy, and the section dealing with diagnostic and therapeutic procedures is of great value to the student and the neophyte intern.

I question the use of glucose water for the neonate or the preference of chloramphenicol over tetracycline for the treatment of Rocky Mountain spotted fever but minor differences of opinion in no way detract from this worthwhile book.

Albert P. Rosen, M.D.

Current Medical Diagnosis and Treatment—1974. Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. Los Altos, California, Lange, 1974. Pp. 1018. (Price not given)

This thick volume is 1974's edition of a "bible" which every generalist should have on his desk for ready reference. Presented in a concise, complete and easily understood manner is a system-by-system, encyclopedic array of disorders, each with practical, clinical advice concerning methods of diagnosis, laboratory and roentgenological findings, and treatment. Each subject then is concluded with an up-to-date bibliography for further reading.

In the short time since my introduction to this book, I have had several occasions to look up conditions seen only rarely in my practice, and have been delighted in the manner and content of the information presented.

I recommend it, without reservation, to all my colleagues in family practice and general internal medicine.

Joseph Peyser, M.D.

Immediate Care of the Acutely Ill and Injured. Hugh E. Stephenson, Jr., Editor. St. Louis, Mosby, 1974. Pp. 266 (Softback—$7.50)

For the first time in the field of emergency medicine in the past many years a book has appeared that relates strictly to emergency medical situations as seen in the field or in hospital emergency departments without drifting to continuing or prolonged care beyond the doors of an emergency department. This book adds impetus to the need for instruction in critical medicine in medical and nursing schools, hospital residencies, and emergency departments. The book covers the field of emergency medicine adequately and is most opportune, in view of federal recognition of the great importance of this specialty in health care delivery. Since the emergency departments are the most important avenue for entry of patients into the hospital, medical and nursing students and other professional medical personnel must be well informed in the field of critical medicine. Equally important is the need to provide medical students with formal instruction in this field. This book satisfies that need. It is an excellent reference for any hospital emergency department.

Jack R. Karel, M.D.

The Malnourished Mind. Elie Shneour. New York, Doubleday, 1974. Pp. 196 ($6.95).

Dr. Shneour offers us a delightful potpourri. He has written a book for the layman designed to energize our power structure into effective action to solve the problems of malnutrition in the United States and all over the world. He makes a good, strong, restrained, and reasonable case. In addition Dr. Shneour gives us a readable review of the evolution of the central nervous system, the basics of nutrition and genetics, the problems of intelligence testing, Piaget's developmental concepts, and many other historical tidbits of interest to the well-rounded physician. The controversy about intelligence and race is handled dispassionately. The author is inclined to the view that the differences reported are more related to nutrition than to genetics.

The book is reasonably priced and easy to read. I must label as unreasonable the line on p. 59 "most hospitals do not keep meaningful records or perform clinical tests to identify malnutrition." However, I recommend the book highly. As I have said in previous reviews, the unanswered problem highlighted by Dr. Shneour is still "how do we get people to do what they know is right."

S. J. Cohen, M.D.

Arthritis. S. P. Lau, M.D. and Dodi Schultz. Garden City, New York, Doubleday, 1974. Pp. 176. ($5.95)

After reading several of the recent lay books on arthritis that have stressed various diets, it was refreshing to read the book by Dr. Blau and Ms. Schultz. Most of the facts contained therein have been fairly well documented by the American Rheumatism Association, and many of them are included in the various pamphlets available to arthritics and to the practicing physician. Certainly this book is valuable only to patients; it actually has very little to offer the physician. Most of the material is explained quite clearly although some is technical that would probably confuse the reader more than help him.

The book is up to date with discussions of the immunosuppressive drugs as well as acupuncture and medications that are yet in the clinical investigatory phase; with one of which this reviewer has had experience. Also, quite typical of our communications medium of today, there was even a section on sex.

In summary it is a good reference book for patients who are interested in finding factual information concerning their disease as generally accepted by the American Rheumatism Association.

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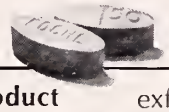

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cautions: Use cautiously in patients with impaired al or hepatic function, possible folate deficiency, rgy or bronchial asthma; and in those with glucose- hosphate dehydrogenase deficiency, where he- ysis may occur. During therapy, maintain adequate d intake and perform frequent urinalyses, with eful microscopic examination, and renal function s, particularly where there is impaired renal ction.

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OF THE MEDICAL SOCIETY OF NEW JERSEY

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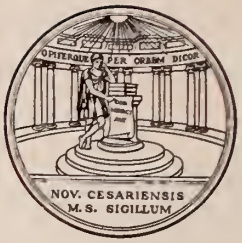

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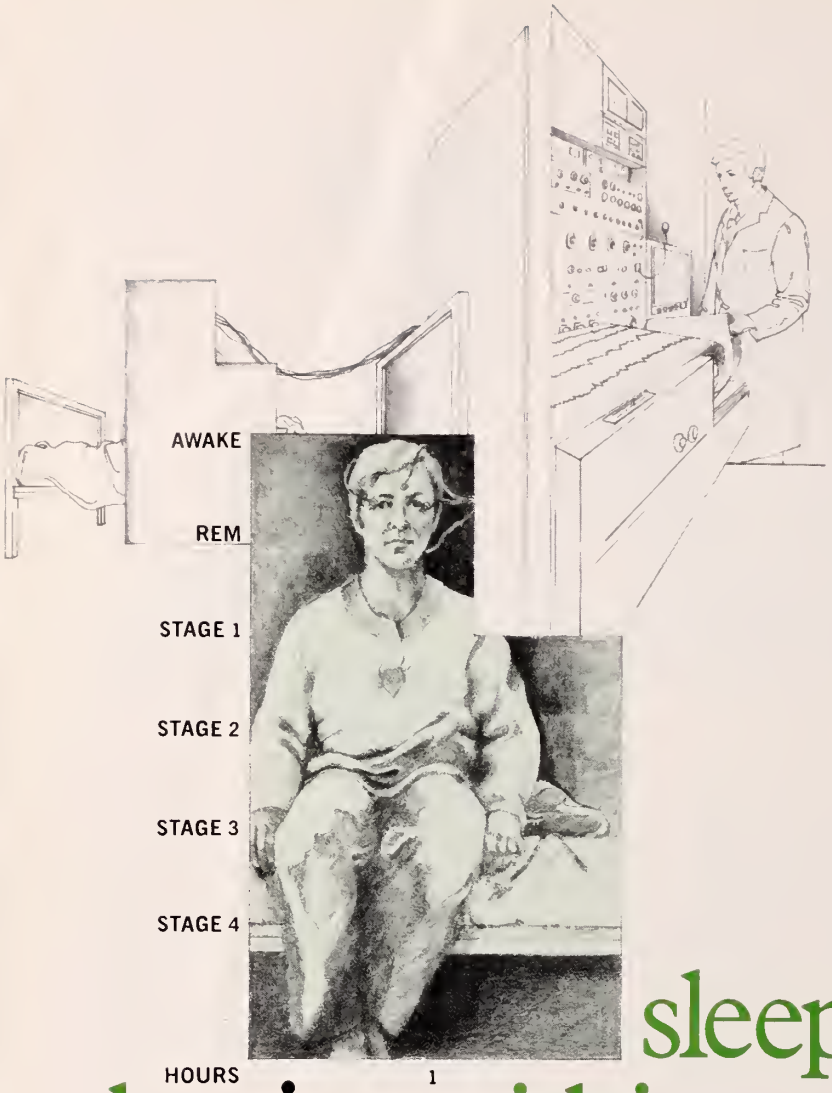

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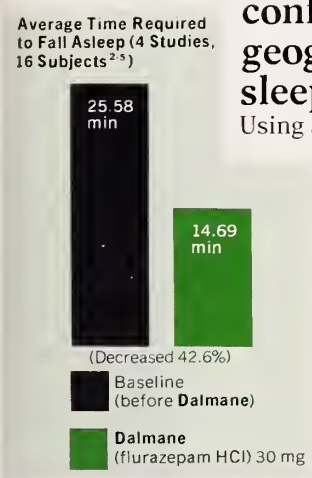

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
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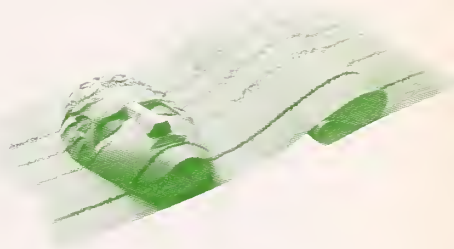

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REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
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EDITORIALS

Dispensing Medications in School

A ten-year-old diabetic child developed insulin hypoglycemia while in class. The condition started gradually, but when untreated progressed rapidly to somnolence. The teacher informed the nurse who wasted valuable time unsuccessfully trying to reach the parents, the family physician, and finally the school physician. By this time, the child was in coma and having convulsions; the after effects were a hemiparesis that lasted 24 hours after admission to the hospital.

Fruit juice or other concentrated carbohydrate would have averted this near-tragedy, but, as a last resort, the school nurse should have been permitted to give an intramuscular injection of glucagon.

Aside from emergency medication, school personnel are often faced with the child who must take routine medication during school hours. It is certainly better to have such children in school, when their medical condition permits, even if school authorities must assume a role which has been uncomfortable in the past. This is especially true in the present day of drug-abuse.

School administrators, school health service professionals, and representatives of the county medical societies should meet to work out a mutually acceptable plan for dispensing both emergency and routine medications in school. The Joint Committee on Health Problems in Education of the NEA and AMA suggests the following guidelines:

"1. The school principal should appoint one responsible person, e.g., the school nurse, or other, to supervise the storing and dispensing of medications.

"2. The medication should be brought to school by the parent of the student. The student should not carry the medication with him or administer it to himself.

"3. For legal purposes, written permission should be obtained for dispensing drugs to a student from both his parents and his physician.

"4. The person in charge of dispensing drugs should keep them in a locked place that is not easily accessible to either students or others in the building.

"5. Each student's medication should have affixed a prescription label including his name, the name of the drug, and directions concerning dosage. Instructions about the duration of the medication period should be included.

"6. The school nurse should give at least the first dose of any medication. She should explain to the child and his teachers all possible side effects of the medication."

Obviously, the final plan should be made known to parents, students, and the community. A.K.

The Physician as a Father Figure

One of the reasons for slow numerical growth of women physicians in this country is the persistence of the image of the doctor as a father figure. In a sense, a doctor-patient relationship cannot be a relationship of equals. It is a relationship of the sick and the well, of the strong and the weak. Many practitioners, indeed, treat the patient as a child and the "doctor knows best" dogma echoes the thesis that "father knows best." This even extends to such matters as to how much truth the patient is entitled to know. Of course, this may mean that the doctor has to tell a lie, and in the ideal emotional climate no one tells lies.

In these days, consumers are clamoring for a share in decision-making about the distribution of the items they buy; tenants want a say in running an apartment house; high school students and their parents speak of "pupil power" or "parent power" in operating schools. So it is not entirely unexpected that many modern health plans envision a role for "the consumer of health services," which means the patient. Of course, in many respects these days, there has been a decline in fatherhood, so it is not unexpected that the physician as a father figure should also be

eroded. The original doctors were priests, and "father" is the title for priest. The father-image role of the doctor is one of his most ancient attributes and something has been lost as this paternal figure has declined in modern egalitarianism. H.A.D.

Reality Orientation

"Senility" is a descriptive term which was favored in yesteryears, but is not quite appropriate as a medical diagnosis. It smacks of a finality and an irreversibility which is depressive. It has an odor, this word senility, of ammoniacal urine and incontinence of bowel. It conjures up an image of wandering oldsters, of food on the lap, and Foley catheters.

"Organic Brain Syndrome" has a nice scientific ring to it. This leads us to subgroups such as Ischemic Encephalopathy or Organic Mental Syndrome (as opposed to Functional Mental Syndrome). Labels such as these may satisfy third-party payers and insurance carriers, but they sometimes interfere with the potential therapy available to these folks—our parents, our grandparents, and potentially even ourselves.

However, there are some professionals, like James Folsom of the Tuscaloosa, Alabama Veterans' Administration Hospital, who have taken "one small step for mankind." Folsom's work on so-called "reality orientation" has begun to teach us that there is a way out of "senility." Techniques such as the "reality board" (a collage of pictures of current events and personalities), the "fact chart" (day, date, month, year, weather report, next holiday, and next meal), and the over-sized clock, which is always visible, help lead the way.

That amazing computer, the human brain, has the data stored in it somewhere. Unfortunately, we do not yet know how to lower the barriers which keep facts stored so well. We do not know how to unravel the short circuits which interfere with ideation. We cannot understand yet how to replace jargon aphasia with useful communicative conversation.

Reality orientation seems rather primitive as compared to the cardiac pacemaker which may rest under the pectoral muscle of the victim of the dementia of aging. Nevertheless, this simplistic yet human approach to these folks, who fill the beds and wheelchairs of countless nursing homes, deserves attention and awareness by the medical profession at large. We are keeping each other alive through the miracles of science which are now commonplace. Don't we owe our elderly patients something more than the inhabitants of a hothouse or a flower garden?

Reality orientation means helping the patient who is confused, from any cause, to know who and where he is, the day, the time, the month, year, and season. It means assisting the bewildered patient to know the people around him. In addition to mechanical devices and a friendly attitude on the part of professional and subprofessional staff, structured intensive reality orientation classes have proved most effective. Daily classroom sessions in the Reality Orientation Program must be supplemented by an approach which is to be carried on 24 hours a day. Each patient-staff contact is meant to be utilized to improve orientation as to time, place, and person. Basic reality orientation can be followed by more advanced challenges as the patients become less confused. Family members should be brought into the activity, by teaching them to be reality oriented. They are taught not to agree with disoriented statements but to keep giving the patient correct basic information. Trips to home, to stores, to restaurants, and elsewhere help realign the befuddled.

Such a human and kind approach to take toward our elderly, our confused and disoriented patients, and our relatives! It was started over a decade ago, but why is it not used more? A.K.

*Folsom JC: The psychiatric team, *Amer Arch Rehab Therapy*, October 1966

ORIGINAL ARTICLES

The transition from adolescence to mature adulthood requires a sense of personal identification. The author describes this rocky road and how role-models may smooth it a bit.

The Search for Identity During Adolescence*

Martin S. Willick, M.D./Teaneck

One of the most essential tasks facing the adolescent is the development of a stable sense of self. This process, which is not completed until early adulthood, is frequently accompanied by a great deal of turmoil which tends to be experienced, although in different forms, both by the teenager and by his parents. This paper explores the nature of the process and will emphasize the role that new models for identification play in the resolution of the crisis.

The young teenager is faced with the realistic task of gradually preparing himself for relinquishing his dependency on his parents. In a few short years, he may be going off to college, taking a job, or even getting married and starting a family of his own. In doing so, he will be confronted with many major decisions which require a sense of personal values, the ability to make independent judgments, and some awareness of the direction he wants his life to take.

Although he may look forward to his growing independence, the task before him is not an easy one. Before reaching puberty, he has relied upon his parents for emotional and material sustenance. He has been dependent on them for guidance, protection, nurturing, and emotional closeness and affection. Furthermore, he has shared their sense of religious and moral values, while learning from them their expectations for him in emotional and ethical behavior and in choice of career.

In order to make the transition, he frequently finds it necessary to break away completely from his family's influence. Parents react with sadness, disappointment, and great hurt to the change in his values and to the fact that he relies more often on the opinions of his peers than on their opinion. The young man usually reproaches his parents for not understanding him or for being "old-fashioned." Sometimes, to make matters worse, he may ignore his parents for long periods of time, so that they do not really know very much about his life.

Preparation for Independence

It is important for parents to realize that the adolescent is going through a necessary change: preparing himself to face the time when he must be increasingly independent of them. Despite an intellectual understanding of this phenomenon, watching their child turn away from them is a hurtful emotional experience. It is not easy for parents to know when to allow the adolescent more freedom, when to hold fast and to insist, in this or that instance, that he must still adhere to their authority.

In addition, the advent of physiological puberty forces the teenager to have another compelling reason to back away from closeness to his parents. He is now thrust quite rapidly into the world of sexual preoc-

*Read before the Section on Psychiatry, 208th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 12, 1974. Dr. Willick is Assistant Clinical Professor of Psychiatry, Einstein College of Medicine, New York.

cupation in fantasy or, gradually, in activity with his peers. If the physiological changes accompanying puberty are sudden and massive, the psychological changes are no less overwhelming. There is a re-emergence of sexual fantasies, often accompanied by masturbatory activity, which had usually undergone repression during the latency years. The threat of closeness to the parents intensifies with the advent of the fantasies, which were originally directed toward the mother and father as primary love objects.

As a result, we find that the young boy, who had previously dutifully and perhaps eagerly kissed his mother before leaving for school, now does not even like it when she so much as approaches him. Nor does the father fare any better in that regard. A teenage girl, who had been the apple of her father's eye becomes shy and restrained with him, while she may become argumentative and irritable with her mother.

My description deals with normal developmental phenomena and not necessarily with psychopathology. This is a time when we see the teenager struggling against his own impulses for closeness with his parents by denying them completely and loudly proclaiming, in words and behavior, his independence from them. In those cases where there have been significant conflicts concerning dependency or sexuality, the turn away from the parents may be even more dramatic and violent.

For example, a 16-year-old girl repeatedly complained about her parents' "babying" her and limiting her freedom. Yet, in her junior year, when she went away to boarding school, she was able to spend only one week away before her anxiety forced her to leave school and return home. This same girl had suffered separation fears when starting nursery school, and was unwilling to go to "sleep-away" camp at age 11.

Another developmental change occurring in early adolescence is the tremendous increase in intellectual capacity and a greatly improved ability to deal with abstract issues. This cognitive spurt enables the teenager to conceptualize and consider ethical, social, and political ideas and then to challenge his parents with more certainty than in the past.

Self-Concept

The consequences of this attempt to break away from the parents are profound and affect every area of the adolescent's functioning. One of the areas to be so affected is that of the adolescent's sense of self, or sense of identity. Although there are distinctions that can be made between these two terms we shall, for simplicity, use them interchangeably in discussing certain subjective phenomena about oneself. These terms are abstractions which have proved useful in discussing personal attitudes toward one's place in society in relation to others, one's sense of continuity between present and past, and one's sense of certainty about feelings, impulses, values, and thoughts.

By and large, throughout adult life we are not made aware of disturbances in our feelings about ourselves. It is only when these disturbances are present that our attention is drawn to this area of personal functioning. However, for the normal adolescent such preoccupations are commonplace and are, in part, a consequence of the process which I have been describing.

At various times during these years the adolescent complains that he "doesn't know what life is all about," or that he "doesn't know why he is living." Questions such as "Who am I?", "What do I really like?", or "What do I really believe in?" are often heard. One young woman began her first session with me by saying that "I don't know where I belong," going on to tell me of the conflicts she was having in attempting to assert her independence from her parents. Others may say that they don't know whether their opinions are their own or those of their parents or their peers.

These confusions are dominant in the clinical

psychiatric picture in schizophrenic and borderline states in which symptoms of depersonalization and derealization are common. These patients, threatened with the loss of distinction between self and others, provide us with a clue to the adolescent experience. The normal teenager is facing a similar struggle as a consequence of fluctuations in his view of himself and his parents—analytically termed the "self and object representation." "Self representation" refers to the thoughts, attitudes, fantasies, and perceptions of ourselves which contain both realistic and unrealistic elements. It includes our conceptions of our wishes and fears, the makeup of our conscience, our expectations for ourselves, and our ideas of our place in the world around us. Our notions and perceptions of our body, our "body image," are also included in this designation. It is not surprising that the fluctuations of these various components of the self during adolescence serve to disrupt the sense of self, which previously had been more stable.

For example, the physiological changes at puberty cause dramatic physical changes. The growth of primary and secondary sex characteristics makes the adolescent experience his body as rapidly altering. One young man recalled that he couldn't believe he was the same person when be began to have pubic hair. Puberty brings with it a profound psychological upheaval, and the adolescent is faced with eruptions of impulses which he frequently has to restrain completely because of the fear of being overwhelmed by them. The most clear-cut of these are sexual in nature. The turmoil encountered is exemplified by the young man who goes through a period of intensive masturbation and then stops abruptly for six months, claiming that such behavior is disgusting and degrading. The same struggles arise over ideals and values, and concern such supposedly innocuous activities as eating or dressing. The formerly avaricious and gluttonous eater will announce that he is becoming a vegetarian. The girl who previously demanded stylish clothing now claims that material needs are part of her parents' "decadent culture" and she herself will do without any fancy or expensive things. The young man who was impressed with the family home and cars will now claim that he, like Thoreau, is going back to Nature, the only real value in life.

The ideal result, of course, is for the adolescent to emerge from his time of turmoil with a firm sense of identity. During the time of rapid changes, however, he is afflicted by intense anxiety and by disruptions and confusions about himself. Despite the intense anxiety experienced by the teenager, we do not consider his confusion about his sense of identity to be an indication of psychopathology. We allow for this disturbance and wait for the resolution of the crisis, which most often occurs during the early adult years.

Those who are familiar with the creative writing and poetry of many adolescents will recognize the themes of confusion about the sense of self that are repeated many times. But not all young people are subjectively aware of the turmoil that they are experiencing. Instead of thinking about it, the struggle that is taking place is revealed in their behavior. Some of them will thrust themselves into new activities which occupy all their time for a few months, but which will then suddenly fail to hold their interest at all. They may get involved with Zen or transcendental meditation or a religious group which differs from their own only to claim later that they can't understand how it ever interested them. Or, they may suddenly want desperately to get into a group or gang with very fixed values or goals, much to the dismay of their parents. It is as though they are trying out new identities while stripping themselves of the old ones, much as though they were changing jackets. Indeed, one of my patients did just that by wearing a motorcycle gang jacket one month and an Army jacket the next.

There is an attempt by some adolescents to use the changes they experience under the influence of drugs to reach what they consider to be their "real selves." They will say that only when they take LSD or "Speed" do they really feel "alive" or in touch with their "true

feelings." Of course, these changes frequently only add to the confusion rather than alleviate it.

There emerges from this turmoil a kind of search for a stable sense of self, or a stable identity. It need not take place consciously or dramatically, but may occur gradually. It may not even involve important issues which distinguish adolescents from their parents. One young man told me that there was a long period of time during which he would disagree with his mother just to disagree; that is, to distinguish himself from her. On one occasion, he screamed "no" and banged the table; to agree with her made him feel like he would be "sucked up into her vacuum" and be too much like her. Most families are familiar with such noisy arguments that seem, on the surface, to be over trivial issues.

Another important problem besetting adolescents is the one that concerns sexual identity, or the final sexual orientation. Young teenagers are often afflicted with fears that they may be homosexual; indeed, homosexual play at this time is not unusual. Conflicts over bisexual impulses contribute to the confusion about the sense of self in relation to sexual identity. The current emphasis on "Gay Liberation" and transsexual surgery will add to the confusion experienced by adolescents.

There is one more historical and social note to be added here. Our modern society now offers the individual almost unlimited choice of career, place of residence, marital status; in short, the role he will play in our world. In years past, these choices were severely limited. A tanner's son became a tanner, a farmer's son took over the farm, and a girl was given no option other than to be a wife and mother. While no one would argue against the increased democratization of society, with the accompanying possibilities for every individual to achieve his full potential, we must recognize that the "unlimited scope of possible lives," as Dr. Peter Blos calls it, must bring with it more anxiety and confusion for the individual.

Nevertheless, this somewhat gloomy and perhaps frightening picture of the adolescent years is only a part of the totality and does not allow for the tremendous developmental advance which takes place during and after the resolution of the personal crisis. This is a process which enriches the teenager's life, makes it possible for him to develop anew a stable sense of identity, now hopefully including his own values, certainties, goals, and principles. He may, for example, return to the values of his parents, which he had temporarily forsaken but which always formed the necessary roots for his sense of self. The model presented to him by his parents may be found to be the most solid of all, and may supply him with characteristics which he will hold on to throughout his life.

Role of Models

This brings us to an important element in the discussion of the search for identity; namely, the role of models used for identification in the shaping of character and consolidation of the personality. Identification is a normal process of development by which the personality acquires certain traits and characteristics that belong to another person. It is distinguished from imitation or copying in that an identification signifies that the trait is now truly an integral and permanent part of the personality and not easily given up or modified. In the course of development there is a range of reactions. These start with mere imitation, like the little boy who wears his father's hat and then says that he *is* Daddy, extend to partial and transient identifications, which are readily modified but may temporarily add to the nature of the personality, and finally to identification proper.

Partial identifications are extremely common throughout life and especially so during the period of adolescent identity crisis. There is an attempt which is sometimes conscious, to become like someone else in order to feel that one has an identity of some sort. A young man of 16, whom I knew, spent a summer on a farm working with the family. When he returned, he not only entertained his friends with stories of life on the farm, but he spoke

with the accent of his hosts and had taken on many of their mannerisms. Six months went by before his language returned to its native New York City dialect.

It is by no means unusual for college or graduate students to take on certain traits of the teachers they admire. A recent survey, studying occupational choices, showed that more college students wanted to enter college teaching than any other field. While some of these attempts to identify with models may be transient, others may develop into solid, stable parts of the personality. Indeed, we consider this a healthy part of development. It should be stressed that there may be a desperate need to identify with someone in order to settle the chaos of the adolescent's disturbance in his sense of self.

The following fragment of a psychoanalysis will serve to illustrate some of the issues that have been raised.

Case Report

A 19-year-old student sought analysis because of confusion over his feelings about himself and a lack of direction in his life. He complained of rapid mood swings, describing periods of self-satisfaction and feelings of superiority which alternated with intense self-doubt and feelings of inferiority. The only boy in a family of four children, he had always felt closer to his mother and had identified with her in respect to his intellectual aspirations. He viewed his father as a passive, weak individual, and disdained his stable but unexciting occupation. At puberty, he had suffered from disturbing feelings of femininity and had made many attempts to model himself after some of his male teachers. One such attempt ended in great disappointment when he learned that the teacher was homosexual.

As a sophomore in college, he formed a close and exclusive relationship with a severely disturbed boy. He gave up seeing girls and spent many hours with his friend discussing poetry, philosophy, and existential concerns about identity and the meaning of life. He now became more anxious and confused about himself and went to see an eminent, older psychoanalyst for consultation. As he talked with this analyst, a Viennese-born scholar and prolific writer, he imagined becoming like him—a Renaissance man who studies poetry, literature, philosophy, and the meaning of life. There were abortive attempts to identify with this man in order to stabilize the feelings of chaos within himself. He was, however, dimly aware that his efforts to identify with one so dissimilar to himself were futile and, moreover, added to his sense of chaos. He asked for a referral to a young American analyst.

When I began to see him, I was able to observe his turmoil, anxiety, and confusion about his place in life and his sexual identity. His own expression of his anguish was "What is my modus vivendi?". Just prior to the start of treatment, his friend had suicided while on an LSD trip. My patient now felt alone and more confused than ever. He told me he felt "fragmented, torn apart, and close to madness." He contrasted himself with his parents, both of whom followed careers and were stable and steady in their pursuits and values.

Although he had initially stated that he felt less important coming to see me after his sessions with the previous analyst, he shortly began to experience strong desires to resemble me. As we discussed the practical aspects of his life and studies, he commented on what he saw as my constancy, stability, and pursuit of an important life work. His early morning analytic session at 8:20 a.m. provided him, he said, with "an anchor into myself to prevent me from slipping off the other end." These were strong words indeed, from a boy who four years previously had thrown away his watch so as not to be shackled with ordinary considerations of time!

His desire to identify with me increased as the analysis progressed. Within a few months, he went to work for his father, whom he had previously seen as weak and passive; he now viewed him with greater respect because of his effectiveness at work. After changing his major, he began to think of teaching as a career. The desire to identify with me reached its height as he reported a dream in which he was looking into the mirror and saw my face but my hair was plastered down. His associations were that he liked me and wanted to be like me, but he had recently been thinking that his hair was too long and he wanted to cut it. He had already shaved off the Christ-like beard with which he had begun analysis. He also pointed out to me that he now wore shoes and a jacket like mine. The patient went on to tell me that he had always imagined himself becoming like someone else, especially when he was dissatisfied with himself. When he had first come to see me he said that his feet weren't on the ground; he was "mixed up inside" and didn't know where he was heading. Now he felt more stable and settled; he was involved in his studies and his job and was even taking an interest in the outside world.

Several changes were evident during this first phase of the analysis. The patient relinquished his grandiose aspirations and identified more with a life style that included a stable sense of self and a more positive masculine identity. He returned with new vigor to heterosexual pursuits and, in general, felt more settled. The rapid, dramatic nature of the attempt to identify with me led to the conclusion that his was a strong need, which partially reflected his fear of losing his sense of self. The identification, which in some respects was transient and temporary, served "as an anchor into myself;" that is, a process which made him feel more stable, less confused, and more certain of himself.

In most adolescents, these processes are at a less conscious level, are less dramatic, and often less desperate. Nevertheless, the gradual building up of character traits, values, attitudes, and goals does take place to a large extent through identification with people who serve as models. Models admired by the adolescent may represent the opposite of his parents' beliefs or may actually be similar to his parents. In the latter case, the solidity of the earlier relationship with the parents is continued with new representatives of them.

As the patient continued to work in analysis, I was able to observe a reaction comparable to the need to

break away from the parents' influence, as described earlier. He began to complain that he felt too dependent on me and that I wanted him to be like me. He objected that he didn't want to be coerced into adopting my views, my outlook, and my values. His protest was highlighted by an incident involving the purchase of a coat. Finding one he liked, the patient was standing in line to purchase it when he noticed that the label said "suburban coat." Since he knew that I lived in the suburbs (although my office was then in Manhattan), he felt a rush of objection. "No! He didn't want to be like me," so the coat was returned to the rack.

During this time, the late 1960's, my patient was participating in a "sit-in" of a university building. He would leave the "sit-in" to come to his analytic hour by climbing out a window, and returned the same way. While there were many motives for his participation in these protests, one was the feeling of solidarity with his friends in a cause for which they were all striving. He described to me how they all locked arms when the police came, and, at that moment, the feelings of togetherness and belonging to a group were very important to him.

We find, then, that there is a two-pronged development thrust: a move toward identifying with selected models and periodic protests which assert one's individuality. This is marked during some phases of adolescence and relatively quiescent during others. The result is the gradual building up of aspects of a personality onto which is primarily stamped characteristics of the parents and, to a more moderate degree, other important people in the life of the individual. The desired goal is the attainment of a cohesive feeling of stability—an awareness of one's place in relation to others, a feeling of certainty about the nature of one's feelings, thoughts, values, and ideals.

Comparison with Psychosis

In schizophrenia, disturbances of identity are common. It is not unusual for patients who are suffering from such symptoms to take on, in a delusional way, the identity of others. A schizophrenic patient may imagine that he is Christ, or Napoleon, or the president of the country. While we have always recognized the grandiose wishes involved in such delusions, insufficient attention has been paid to an observation of Dr. Robert Bak. He stated that assumption of a new identity serves to demarcate the person's sense of self at a time when he is truly fragmented. Such a disintegration into a truly regressed state is called a "loss of ego boundaries." The assumption of a new identity is an attempt to put a halt to the severe personality disintegration. In the adolescent, there is no psychosis, loss of ego boundaries, nor real belief in the change of identity. Although the degree is less than in the psychotic patient, the adolescent's search for identity serves to bolster the individual when he feels his sense of self to be shaky, fluctuating, and unstable.

Summary

One of the most essential maturational tasks facing the adolescent is the development of a stable sense of identity. This necessitates a gradual relinquishing of close ties to his parents which often includes a rejection of their values and way of life. This paper explores the nature of that process, the turmoil which occurs during this phase of development, and the attempts to resolve the conflict, particularly by choosing new models with whom to identify. A discussion of the psychoanalysis of a young man illustrates the major themes.

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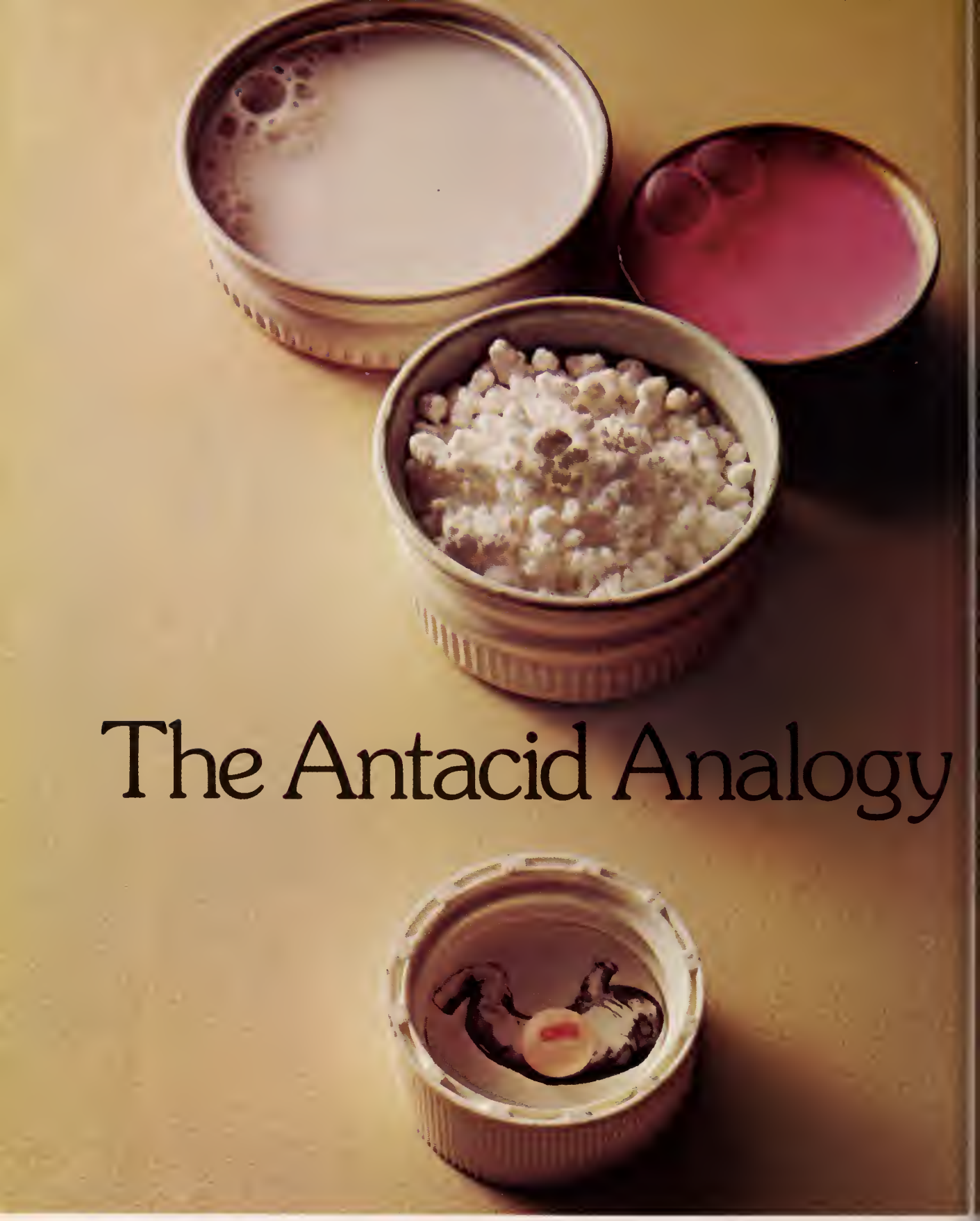

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

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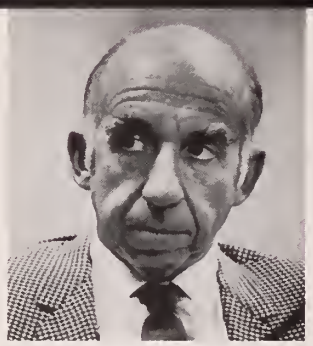

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At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, however, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. This does without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative for a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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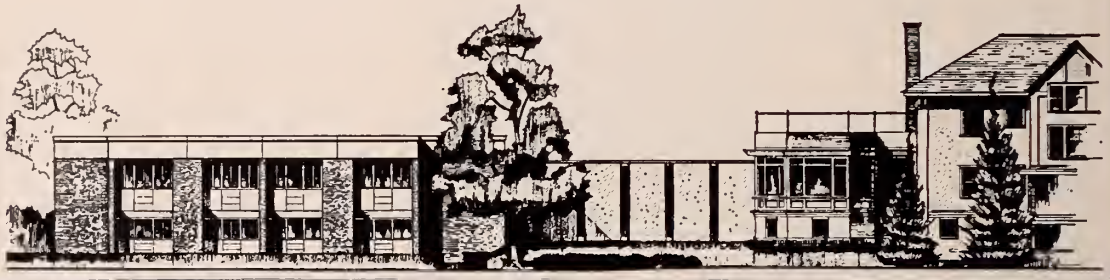

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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Three cases of primary lung abscess in childhood seen in ten years at a children's hospital are presented and the literature reviewed. An individual approach to each patient combining sound surgical and medical principles is essential. Drainage, culture, and appropriate antimicrobial therapy are interdependent therapeutic modalities in this condition.

Primary Lung Abscess in Childhood

Diller B. Groff, M.D. and Richard H. Rapkin, M.D./Newark*

Although lung abscess is a disease entity which has been well reported in the recent medical literature, there has been some confusion regarding the classification of lung abscess within the spectrum of pyogenic pulmonary disease. Some authors have mentioned primary lung abscess,[1] and others have proposed classification into simple lung abscess and lung abscess associated with another disease.[2] One review of patients with lung abscess excluded patients with neoplasms, infarcts, cysts, tuberculosis, mycoses, and staphylococcal infections;[3] another excluded patients with pre-existing bronchiectasis or abscesses developing during the course of specific bacterial pneumonias.[4] Obviously, evaluation of therapy and prognosis cannot be compared in such diverse series.

There has been a paucity of pediatric literature dealing with lung abscess except as a development during the course of staphylococcal pneumonia. In a review by Mark and Turner,[5] 83 cases were found in ten years at the Hospital for Sick Children and 25 were considered to be primary. These authors defined primary lung abscess as: "those cases that occurred in children who had been previously well or in whom a recent illness was not considered to be related to the subsequent formation of lung abscess." In another series,[6] only six abscesses in childhood not preceded by an episode of pneumonia were found in a 25 year period at the Indiana University Medical Center.

Recently, we saw a child with primary lung abscess as defined by Mark and Turner.[5] The diagnosis and management of this patient and a review of the two other children with this entity seen in the past ten years at Children's Hospital of Newark form the basis for this report.

Case Reports

Case 1—A thirteen-year old boy, with a history of asthma, was admitted in 1971 because of fever, cough, left back pain, and a six-pound weight loss in seven days. One week prior to the onset of symptoms he had been seen by a physician for a routine check and was well. Physical examination showed an acutely ill boy with a temperature of 40°, splinting of the left hemithorax and lungs clear to auscultation and percussion. Chest x-ray showed an abscess in the left upper lobe. (Figure 1) The white blood cell count was 21,500 with 72 segs, 7 bands, 1 myelocyte, 15 lymphocytes and 1 monocyte. Despite treatment with intravenous penicillin and postural drainage the patient continued to be febrile and lose weight. Chloramphenicol was added to the antibiotic schedule without improvement. On the ninth hospital day, bronchoscopy was performed but no pus could be drained from the upper lobe area. At the same procedure in the x-ray department under fluoroscopy, an arterial catheter was passed transbronchially into the left upper lobe (Figure 2) and twenty cc's of pus were evacuated from the abscess. The patient's temperature fell from 40° to 38.3° within 24 hours after the transbronchial drainage and culture of the pus grew out coagulase positive staphylococcus aureus resistant to penicillin and ampicillin but sensitive to methicillin. He was started on methicillin and within 48 hours his temperature was normal. He was discharged on the fifteenth hospital day and remained well after a ten month follow-up.

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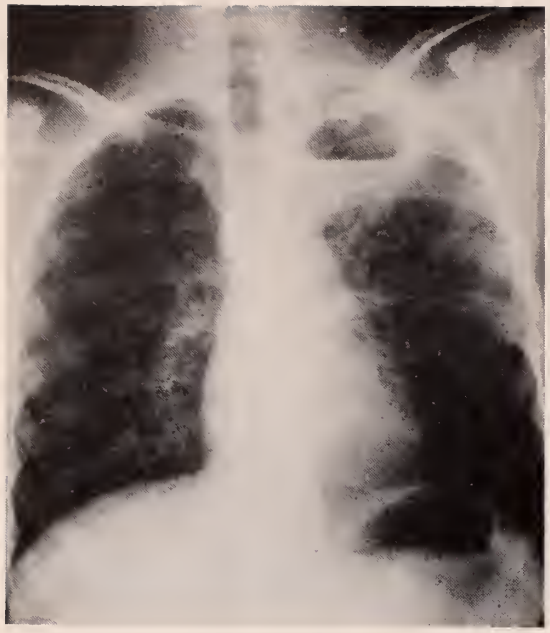

Figure 1—PA of the chest showing a lung abscess in the left upper lobe with air fluid level.

Figure 2—Spot films showing catheter passed transbronchially from the trachea into the lung abscess.

Case 2—A five-year-old female was admitted in 1968 for anorexia and cough of one week's duration. There was no previous history of illness or exposure to tuberculosis. Physical examination revealed a small, moderately ill child with a temperature of 38.6° and respiratory rate of 36. Rales and dullness were found in right base posterior. Chest x-ray revealed a cavity in right middle lobe containing an air fluid level. The Hgb was 10.0, WBC 14,300 with 71 segs, 26 lymphs and 3 monos; sickle cell test and PPD (IS) were negative. Blood culture, ASO, coccidioidin and histoplasmin skin tests were negative. The patient was treated with ampicillin; x-ray showed gradual resolution of the abscess over a three-week period without surgical intervention or bronchoscopy. The child was discharged on the 25th hospital day. He was well and his x-ray showed only mild residual abnormality. No follow-up was available.

Case 3—A seven-year-old female was admitted in 1961 for cough and fever of one week's duration. Past medical and family histories were non-contributory. Physical examination showed a mildly ill child with a respiratory rate of 24 and temperature 39°. Physical examination of the lungs showed rales and dullness at the right base. Her hemoglobin was 9.3 grams and the sickle cell test was negative. WBC 18,100 with 86 segs, 8 bands, 6 lymphs; PPD (IS) was negative. Chest x-ray showed a right lower lobe cavity containing a small amount of fluid. Treatment was begun with penicillin and tetrocycline. Improvement was rapid without surgical intervention. By the eighth hospital day the cavity remained but the patient was afebrile. She was discharged and lost to follow-up.

Discussion

Primary lung abscess in childhood is rare. Only three cases could be found in our hospital in ten years during which time there were approximately 25,000 pediatric admissions. Since primary lung abscess in children is seen infrequently, the responsible physician may be unsure of the best method of treatment. A method of therapy which was successful in a previous patient may be inappropriate in a later case, while improvements in total patient care may allow new techniques to be applied.

A second major deficiency is that pathogenic organisms in lung abscesses reported in the literature may not have been obtained directly from the cavity and cultured by aerobic and anaerobic techniques. Sputum cultures have been used to infer what may be in the abscess but this is unreliable. Only the early studies of Smith[7] and Cohen[8] provide direct culture information; these authors suggest that infection with anerobes such as fusospirochetal organisms and bacteroides are frequent. The dilemma of choosing appropriate antimicrobial therapy is significant since many other organisms, including staphylococcus,[9,10,11] have also been associated with primary abscess. In order to bring the management of primary lung abscess up to date, it is imperative that cultures of material from the lung abscess itself be obtained.

Another unsettled question relates to the importance of drainage of the abscess. Classical surgical principals would suggest that it is. Collins, *et al.*[1] found surgical drainage necessary in 61 per cent. On the other hand, Aber-

nathy[3] found that the great majority of patients responded to antibiotics alone. Mark and Turner[5] report that drainage is warranted in most children but stressed that the drainage is usually accomplished by bronchoscopy and physiotherapy. Poppe, *et al.*[12] reported 48 patients with primary lung abscess and concluded that bronchoscopic drainage and antibiotics will cure the majority of patients. They also showed that resection or external drainage should be reserved for those patients who did not demonstrate x-ray improvement in several weeks.

Our patients shed some light on the questions of etiologic agent and management. Two patients (case 2 and 3) had no drainage procedure at all and improved, although no follow-up is available. Case one was treated medically but did not get better until his abscess was drained, the etiologic agent identified, and appropriate therapy begun.

In treating abscesses elsewhere in the body, the physician usually obtains material for culture and sensitivity for diagnostic purposes at the same time that therapeutic drainage of the abscess is carried out. There is no reason why these same principles should not be applied to the management of primary lung abscess, provided the physicians and surgeons follow procedures which insure the integrity of the thoraco-pulmonary system. A basic understanding of thoracic surgical principles, combined with newer technological advances in radiology and surgical instrumentation, allow a more direct attack upon primary lung abscesses.

The pediatrician and the pediatric surgeon must select the best method of obtaining material from the abscess and provide an opportunity for drainage at the same time. The two avenues of approach to an abscess, without major surgery, are percutaneous, through the chest wall, or transbronchially through an endotracheal tube into the major bronchus involved with the abscess.[13] The route to be used is based upon the location of the abscess on plain x-rays of the chest. If it appears to be in the lower lobes and near the chest wall, percutaneous needle aspiration is the preferred route. If a needle can be inserted into the abscess and pus obtained, then a small chest tube can be safely inserted into the cavity to promote further drainage of the abscess. An abscess located more centrally, or in the upper lobes posteriorly, is best drained transbronchially with a catheter under fluoroscopic control. Adherence to sound principles of insertion and management of chest tubes will prevent the introduction of a pyopneumothorax or a persistent bronchopleural fistula. Competent pediatric anesthesia and radiology support enable transbronchial drainage to be performed safely.

Culture of the cavity is imperative if the patient does not respond to initial therapy with broad spectrum antibiotics. Further, it is our strong feeling that an attempt should be made to obtain material for culture directly from any primary lung abscess in a child. If one is successful in accomplishing direct aspiration of the abscess, and we believe it can be safely attempted in most cases, then it should be possible to establish drainage of the abscess either into the bronchus or externally by means of a properly inserted and maintained chest tube. A further advantage of this therapeutic approach to primary lung abscess is the potential for shortening hospitalization and the total period of convalescence, which is particularly important in the growing child.

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65 Bergen Street

Health Care Is Personal Responsibility

Good health care for all Americans is unlikely to be achieved without enormous social progress against poverty and ignorance, says an editorial in a recent issue of *JAMA*.

"Health care, like life, liberty and the pursuit of happiness, is said to be a right.

"If so, it is also undeniably a responsibility . . . that begins at home or in whatever environment the individual resides. Abuse of alcohol and other drugs, cigarette smoking, obesity, choice of an inadequate diet—these and other manifestations in our society bespeak the dereliction of responsibility by many persons.

"Although it may be a right, health care is unlikely to be achieved without enormous social progress."

The editorial is a comment on the oft-expressed reasoning that a nation that can send men to the moon should be able to solve the problem of health care delivery.

"There is no doubt that technology has contributed mightily to health care. Thirty years ago, management of people's health lacked computers, effective machines for hemodialysis, by-pass equipment for cardiac surgery, autoanalyzers, and devices for replacing degenerated joints, to name a few of the important advances. There were few drugs that could be used for specific treatment of diseases, and few water supplies contained sufficient fluoride to prevent dental caries."

But there are limits to technology in health care and a comparison to the moon trips is not valid, the editorial says.

"Development of the means to send men to the moon, though expensive, was relatively easy. The engineers and other scientists who made space voyage feasible were working with inanimate objects, did not involve the whole population, and did not arouse intense feelings. In contrast, health care involves all the people, a mass of highly differentiated beings."

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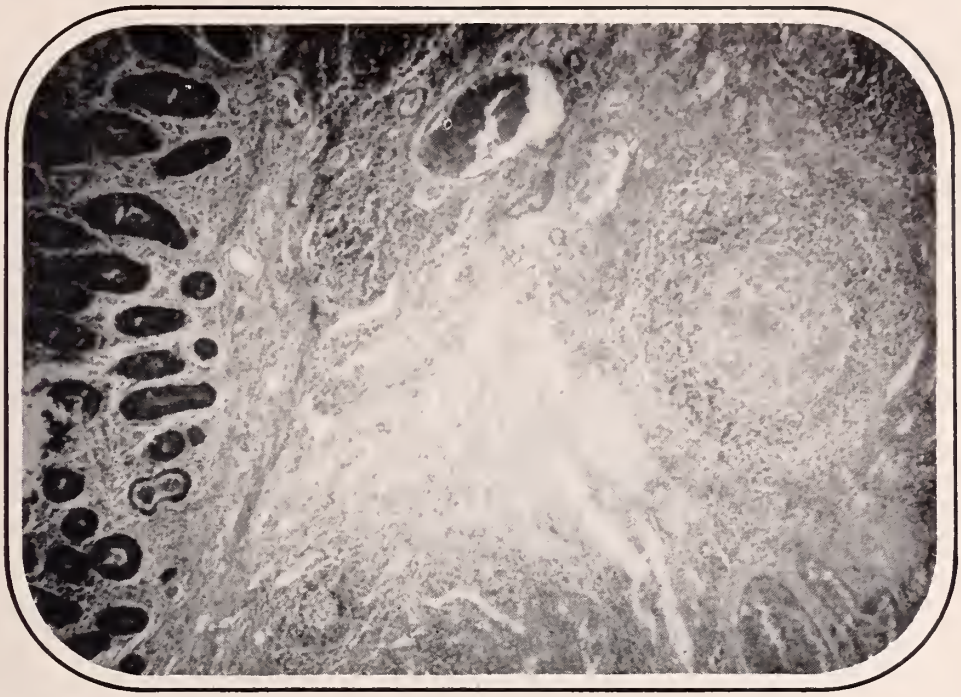

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*Granulomatous colitis is revealed in this photomicrograph. Diagnostic signs show full thickness involvement of the bowel wall, including mucosa and muscularis, by a granulomatous inflammatory process. In ulcerative colitis, a nongranulomatous inflammation is present, generally limited to the mucosa.

The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

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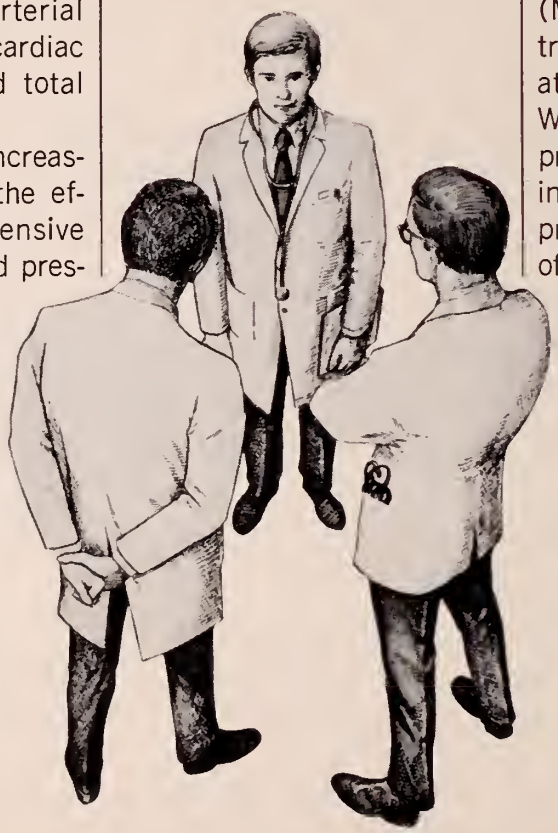
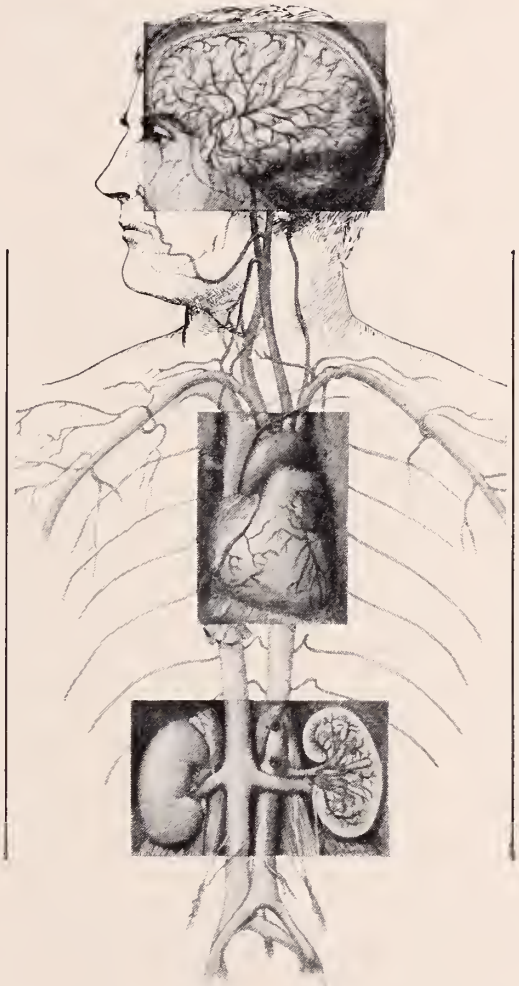


the more physicians rely on this unique antihypertensive

lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.



Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

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For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

ALDOMET® (METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

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addendum

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An 18-year-old girl with acute virus B hepatitis complicated by salicylate intoxication presented clinically with fulminating encephalopathy, hypoglycemia, hypoglycorrhachia, and hyperventilation with respiratory alkalosis, findings typical of Reye's syndrome. Liver biopsy revealed fatty infiltration unexpected in uncomplicated viral hepatitis. This case lends support to the view that Reye's syndrome is not a specific disease entity but a final pathway for hepatic insults.

Viral Hepatitis and Salicylism Simulating Reye's Syndrome

Leonard J. Lyon, M.D., Michael A. Nevins, M.D., et al./Paramus*

Since the report of Reye and associates in 1963,[1] numerous investigators have confirmed the existence in children of a syndrome of acute cerebral edema with fatty metamorphosis of the liver and other viscera. The etiology of Reye's syndrome remains unknown and it is not clear whether Reye's syndrome is a specific disease entity, or a nonspecific expression of various insults in young patients. The syndrome often has been associated with viral illnesses including influenza B,[2] varicella-zoster,[3] reovirus,[4] infectious mononucleosis[5] and rubeola,[6] among others, as well as unidentified upper respiratory infections and exanthems. A toxic etiology has been postulated in some instances.[7,8] An association with viral hepatitis has also been suggested on epidemiologic grounds.[9]

The present report describes an 18-year-old girl with viral hepatitis complicated by salicylism whose clinical and pathological findings were so similar to those of Reye's syndrome that the diagnosis of Reye's syndrome could not be completely excluded. Although Reye's syndrome has not yet been reported in patients with proved viral hepatitis, this case helps support the thesis that Reye's syndrome may be a final common pathway for several different disease processes.

Case Report

An 18-year-old girl was admitted to Bergen Pines County Hospital on November 7, 1972, because of psychotic behavior. Her past health had been excellent. Six months previously she underwent an abortion at another hospital. No transfusions were given. She took Orthonovum® tablets cyclically until the onset of the present illness, but emphatically denied recent injections or illicit drug use.

Eight days prior to admission she developed cough and malaise. She began to take aspirin. The total dosage is unknown, although on previous occasions her parents had expressed concern about her excessive use of salicylates. Five days prior to admission she developed nausea and vomiting followed in two days by headache, tinnitus, and diminished hearing. On the day of admission she experienced frightening hallucinations and began screaming, tearing her hair, and biting herself.

Examination on the night of admission disclosed hyperventilation, agitation and disorientation, temperature 101°, and widely dilated pupils with sluggish light reactions. There were no focal neurological signs and the remainder of the examination was unremarkable. By the following day she had become comatose; her temperature was 104° and pulse 150 per minute. Bilateral Babinski signs and bilateral papilledema were present but no nuchal rigidity was observed. There were widespread ecchymoses with obvious jaundice and hepatomegaly to 2 cm below the right costal margin.

Initial laboratory workup revealed WBC 13,500 with normal differential count, hemoglobin, and hematocrit. Blood glucose was 37 mg, per 100 ml, sodium 135 meq/l, chloride 105 meq/l, potassium 3.2 meq/l and CO_2 15 meq/l. Arterial pH and blood gases were compatible with respiratory alkalosis (table I). Serum salicylate level was 40 mg per 100 ml. Lumbar puncture (traumatic) revealed 811 RBC and 14 WBC per cubic mm, glucose 29 mg per 100 ml, protein 42 mg per 100 ml, and negative Pándy and VDRL. Because of her agitation, manometrics could not be performed. Repeat lumbar puncture on November 9, disclosed an opening pressure of 240 mm of water, 6 WBC per cubic mm, glucose 77 mg per 100 ml, and protein 25 mg per 100 ml.

Because of the hypoglycemia, 100 ml of 50 per cent

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Table I
Pertinent Laboratory Data

Date	11/7/72	11/8	11/9 A.M.	11/9 P.M.*	11/10	11/11	11/13	11/15	11/22	11/28	12/14	12/28	1/25/73
Bilirubin, total (mg%)		11.0	10.0		9.3	11.0	13.5	12.0	5.1	3.9	2.6	2.0	0.8
Bilirubin, direct (mg%)		6.8	6.0		4.8	6.5	9.5	7.9	2.6	2.0			
SGOT I.U.		1789	650		525	460	250	115	115	120	88	43	30
Alk. phosphatase I.U.			100		83	83	95			55			
Au Antigen						1:160		+	+		—	—	
Calcium (mg%)		8.0	8.8		7.9	8.0	8.6						
Phosphorus (mg%)		1.3	1.0		0.5	0.7	3.3**						
Arterial pH	7.51	7.55	7.53	7.61	7.56								
Arterial pCO_2	18	21.5	20	20	23.0								
Arterial pO_2	97	86	49	82	120								
Ammonia (mcg%)					79								

* After tracheostomy
** After phosphate supplements

dextrose in water was infused intravenously followed by a 100 per cent glucose infusion. Although the blood glucose remained normal thereafter, there was no clinical improvement. At the time cutaneous bleeding was first noted, prothrombin time was 88 seconds, partial thromboplastin time was 42 seconds and stool guaiac was 3+ positive. Consumption coagulopathy was considered, but excluded on the basis of normal serum fibrinogen and platelet count. The serum salicylate level rose further to 55.6 mg per 100 ml, the bilirubin was 11 mg per 100 ml., LDH 1150 mlu/ml, with fraction 5 (liver) increased. SGOT 1780 mlu/ml, alkaline phosphatase 100 mIu/ml. Normal blood studies at this time included the cholesterol, uric acid, lactic acid, direct and indirect Coomb's tests, VDRL, monotest, barbiturates, serum osmolarity, as well as creatinine clearance and cultures of blood, urine and spinal fluid. Urinalysis revealed pH 5.5, specific gravity 1,032, protein 2+, glucose negative, 5-8 RBC and 8-12 WBC per high powered field. Serum protein electrophoresis showed low albumin and low $alpha_1$ globulin, although $alpha_1$ antitrypsin was normal. Venous blood ammonia on November 10 was 79 mcg per 100 ml (normal 18-48).

The clinical impression of a fulminating viral hepatitis with acute yellow atrophy of the liver was apparently confirmed by the finding of Australia antigen in the serum at a titre of 1:160 (counter immunoelectrophoretic method). Konyne was administered to restore clotting factors, and she was placed on a hepatic coma regimen including nasogastric suctioning, antacids, neomycin, and cleansing enemas. During the day she continued to decline, developing decerebrate posture and becoming unresponsive to all stimuli. She was placed on a hypothermic blanket to control her temperature, and treated with four plasmaphereses as well as 125 mg methyl prednisolone, administered intravenously every six hours, and prophylatic garamcin.

On November 9 she developed major seizures for which diphenylhydantoin was administered. A tracheostomy was performed because of hypoxia and to help control bronchial secretions. Hemodialysis was being considered, but by late that night, pupillary and corneal reflexes returned and she began to respond to painful stimuli.

From then on her course was one of progressive improvement. Calcium phosphate syrup was added because of hypophosphatemia. By November 11 she was responsive to verbal stimuli. Thereafter, she was afebrile. Her corticosteroids were rapidly tapered and other medications were discontinued. At this point her rapid clinical progress and the relatively moderate hepatitis as judged by the serum enzymes seemed out of keeping with the fulminating presentation and severe encephalopathy. Although salicylate intoxication had also been demonstrated, the association of severe hypoglycemia raised the possibility of an additional diagnosis, namely, Reye's syndrome. On November 16 she underwent a percutaneous liver biopsy (figures I and II) which revealed inflammation, bal-

Figure 1—Low power view of liver tissue showing fatty metamorphosis and ballooning degeneration (x84)

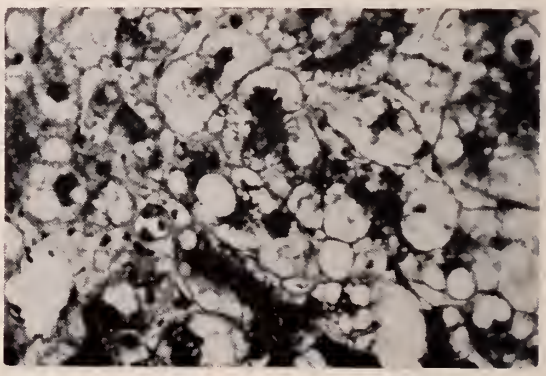

Figure 2—High power view demonstrating ballooning degeneration with fatty metamorphosis of the parenchymal cells (x378)

looning degeneration and cholestasis typical of viral hepatitis, as well as fatty infiltration of the macrovesicular and microvesicular type. She was discharged from the hospital on November 28. There has been no evidence of central nervous system residua from her two days in coma, and her liver chemistries have returned to normal (table I).

Discussion

The liver biopsy and the repeated demonstration of Australia antigen with diminishing titers until finally it was no longer demonstrable by counter immunoelectrophoresis make it clear that our patient had an acute hepatitis B infection rather than chronic Au antigenemia. Of particular interest is the fact that the typical features of Reye's syndrome were also displayed, i.e., fulminant encephalopathy following a mild prodrome with normal cerebrospinal fluid except for hypoglycorrhachia, hypoglycemia, vomiting, and hyperventilation with respiratory alkalosis. Her liver biopsy demonstrated fatty metamorphosis, an unexpected finding in uncomplicated viral hepatitis, but consistent with Reye's syndrome.

The crucial question is whether a diagnosis of Reye's syndrome is warranted since her symptoms might all have been due to hepatitis plus salicylism, and the fatty liver a result of her corticosteroid therapy. Certainly, the clinical and pathological findings cannot be ascribed to the hepatitis alone. Although hypoglycemia and cerebral edema may complicate massive hepatic necrosis,[10] there was no indication of massive hepatic necrosis by either the serum enzymes or the liver biopsy in our case. We are not aware of any reports describing such a profound encephalopathy in viral hepatitis when the hepatic involvement was as moderate as that of our patient. Central nervous system involvement is rare in hepatitis without massive necrosis, and when it occurs the symptoms are most often headache and stiff neck, sometimes accompanied by focal motor signs suggesting poliomyelitis,[11,12] however, none of these findings was present in our patient so it is very unlikely that hepatitis per se was responsible for her encephalopathy.

On the other hand, failure of hepatic metabolism of aspirin may have contributed to the elevated serum salicylate levels with consequent aggravation of bleeding and hypoglycemia. The serum salicylate levels were in the toxic range on the second day when she lapsed into deep coma. Moreover, she displayed typical signs of salicylate intoxication, i.e., tinnitus followed by hyperventilation with respiratory alkalosis, making it likely that aspirin was the main cause of her encephalopathy. Finally, the patient's initial clinical improvement occurred within 24 hours after four plasmaphereses. This could indicate a therapeutic effect of the exchange by reducing the serum levels of salicylate, ammonia, and possibly other metabolites.

Nevertheless, the similarity of her clinical course to that of the patients with Reye's syndrome was striking. Moderate levels of serum salicylates have been found in some cases of Reye's syndrome, and a history of salicylate ingestion obtained in many others. The similarity of the clinical findings in Reye's syndrome and salicylism is so great that some investigators have found difficulty in making the differential diagnosis,[13] while others have been led to conclude that aspirin may play a role in the pathogenesis of Reye's syndrome.[14,15] Indeed, with our current understanding of Reye's syndrome, it is difficult to completely rule out that diagnosis in the present case.

Until the etiology of Reye's syndrome is established, the diagnosis remains a clinical one. Although the usual pathologic finding in fatal cases of Reye's syndrome is diffuse, small droplet fatty infiltration throughout the liver,[1] other investigators have suggested that severe fatty metamorphosis is not a *sine qua non* for the diagnosis when the clinical presentation is typical. In fact, considerable variation in fat globule size can be seen in resolving Reye's syndrome.† In one case, the liver contained no fat at all on the seventeenth day of illness.[17] Therefore, in the present case, a diagnosis of Reye's syndrome must be a tenuous one because of alternative explanations for her illness. Nevertheless, the similarity to cases that are generally accepted as Reye's

† Glick, TH: Personal communication

syndrome is so great that our patient lends support to the view that Reye's syndrome is a final common pathway resulting from various illnesses possibly aggravated by salicylates. Perhaps hepatitis B virus should be added to the list of agents capable of initiating Reye's syndrome, and the disease should not be thought of as confined to children, but also considered in the differential diagnosis of obscure encephalopathies in adults.

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Bergen Pines County Hospital

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On review of the case, the state supreme court found that the appellate court erred in sustaining the reduction of the awards. The court modified the appellate court's decision, directing that judgment be entered according to the awards originally made by the jury.

Citation, Vol. 27, No. 11

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WRITE FOR LITERATURE AND SAMPLES
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A study is reported comparing serum lipids and ions of two randomly selected groups of volunteers drawn from similar industrial sites in Phillipsburg, New Jersey, and Easton, Pennsylvania. Dietary patterns and water supply are similar for both groups except for the addition of fluoride to the water supply of the Easton subjects. No significant differences in serum cholesterol, triglycerides, fluoride, and lithium were noted. With the finding of similar age specific mortality rates for heart disease, it appears that fluoridation is not contraindicated from this point of view.

Effect of Fluoridated Water Upon Serum Lipids, Ions, and Cardiovascular Disease Mortality Rates

M. L. Bierenbaum, M.D., A. I. Fleischman, Ph.D., et al.*/Montclair

A significant negative correlation has been demonstrated between the incidence of arteriosclerotic cardiovascular disease and the hardness of drinking water.[1] The calcium content of the water has been implicated as one of the strongest correlates.[2] Because calcium supplements have been shown to lower blood lipids,[3] a logical assumption would be that water hardness operates *via* this mechanism. In previous studies utilizing areas of the United States[4] and the United Kingdom,[5] it was noted that in the hard water areas with significantly lower cardiovascular mortality rates, the serum cholesterol and triglycerides were either essentially the same or significantly higher than in the soft water areas with the higher cardiovascular disease mortality rates. Significantly higher levels were observed in some serum ion concentrations, that is, magnesium, chromium, copper, and cobalt, in the hard water areas. More recently Masironi[6] reported that fluoride ion concentration might be importantly implicated, and Voors[7] noted that the lithium ion concentration could add a significant protective factor.

The present study is an attempt to evaluate the role of these latter two trace elements in cardiovascular disease rates.

Methods

Two matched populations in Phillipsburg, New Jersey, and Easton, Pennsylvania, were selected for evaluation. These two areas, which are adjacent to each other but on opposite sides of the Delaware River, draw their raw water supply from the same source. The water has been flouridated in Easton, for the past 15 years, in an attempt to control dental caries, but not in Phillipsburg. Table I presents the average comparative water analysis of multiple samples obtained from both plant and home sites of volunteers in the Phillipsburg and Easton areas and determined in our laboratories. It can be seen that the total hardness is the same in both areas. The slightly but significantly lower calcium and magnesium in the Easton area is probably due to the treatment of the water with fluorosilicic acid. Table II compares the water consti-

*From the Atherosclerosis Research Group, St. Vincent's Hospital, Montclair: Co-authors are R. Stein, M.D. and T. Hayton, Ph.D. This study was supported by a grant from the Essex County Heart Association.

Table I

Water Analysis from Multiple Random Sites in Phillipsburg, New Jersey, and Easton, Pennsylvania

	Phillipsburg	*Easton*		*Phillipsburg*	*Easton*
	Mg/L			*Mg/L*	
Color	0	5	Nitrite	0.05	0.03
Odor	0	0	Arasenic	Neg.	Neg.
Turbidity	0	0	Barium	Neg.	Neg.
pH	7.0	7.5	Cadmium	Neg.	Neg.
Total solids	130	103	Chromium	Neg.	Neg.
Total hardness	96	94	Lead	0.01	0.01
Chloride	9	11	Zinc	0.40	Neg.
Alk.pH 4 as $CaCo_3$	79	35	Calcium	26.4	18.4
Nitrate	Neg.	Neg.	Magnesium	7.2	4.3
Iron	Neg.	Neg.	Copper	Neg.	Neg.
Manganese	Neg.	Neg.	Ammonia	2	2
Fluoride	Neg.	1.13	Phosphate	Neg.	3
Detergent	Neg.	Neg.	Cyanide	Neg.	Neg.
Sodium	9.1	8.2	Potassium	1	1

Table II

Comparison of Water Analyses by Departments of Health for Phillipsburg, New Jersey and for Easton, Pennsylvania

	Phillipsburg	*Easton*
Color	0	5
Turbidity	0	<5
pH	7.0	7.5
Total solids Mg/L	160	134
Chloride Mg/L	13	9
Alkalinity Mg/L	76	58
Nitrate Mg/L	2.35	0.4
Iron Mg/L	0	0.15
Fluoride Mg/L	0	1.0

Table III

Resident Deaths from Heart Disease for Phillipsburg, New Jersey and Easton, Pennsylvania

Phillipsburg		Population 18,510		
Code #	*Total*	*15-24*	*25-44*	*45-64*	*65 plus*
390-398					
402-404					
410-429	131	3	27	101
Rate/100,000	708	16	146	546
Easton, Pa.		Population 30,000		
Code #	*Total*	*15-24*	*25-44*	*45-64*	*65 plus*
390-398					
402-404					
410-429	194	5	37	152
Rate/100,000	647	17	123	507

tuent values reported by the Pennsylvania and New Jersey State Departments of Health for the two cities for the year 1970. The values from both sources are very similar, and are in close agreement with the data we obtained. So far as could be discerned, the fluoride content of the water supply is the major difference in environment that the residents of the two communities have, thus creating a test model for evaluating the long-term effects of fluoridation of a water supply. Lithium intake appears to be similar for both communities. Socio-economic factors and work activity appear to be identical.

In order to evaluate any significant role of these ions on a long-term basis upon cardiovascular mortality rates, a study of the vital statistics in this regard was undertaken. The mortality data for the two cities for the year 1968, and resident deaths for selective causes and age groups for both communities are presented in Table III. It is evident that the raw data and the rates per 100,000 population, including the varying age groups, are similar, with no apparent statistically significant difference.

Following this observation of no difference in cardiovascular mortality data between the two areas, 50 randomly selected subjects from two similar industrial concerns were drawn from each area. The subjects were all males, and of similar socio-economic and ethnic background. In Phillipsburg the mean age was 43.8 years, and in Easton, 43.0 years. In order to ensure a significant water effect, only subjects in extended residence—for at least 5 years—in the respective communities were selected. Extended residence was construed to mean both live and work in the community. All subjects with diabetes, hypothyroidism, nephrotic syndrome, or alcoholism were eliminated, since they might alter lipid and nonlipid blood parameters. In order to minimize possible seasonal variations in blood parameters, sampling in both areas was done with-

in one month's time. All serum specimens were transported to the project laboratory for analysis, to ensure analytical uniformity. Of the original 50 randomly-selected subjects from each community, 41 from each area agreed to participate in the study, and are the basis of this report.

The analytical methodology for determining serum phospholipids, cholesterol and triglycerides, calcium and magnesium have been reported previously.[4,8] Fluoride ion was determined by the method of Fry and Travis[9] employing a fluoride ion electrode, while lithium was assayed flame-photometrically.[10]

Table IV

Serum Lipids and Ions

	Phillipsburg	Easton
Total Cholesterol Mg/dL	189.0 ± 18.55*	178.2 ± 16.58
Triglycerides Mg/dL	194.0 ± 30.00	190.7 ± 22.76
Phospholipids Mg/dL	170.6 ± 2.12	204.2 ± 1.67**
Fluoride, uM/L	0.46 ± 0.01	0.41 ± 0.02
Lithium, mEq/L	0.69 ± 0.01	0.64 ± 0.01
Calcium Mg/dL	8.88 ± 0.26	9.53 ± 0.27**
Magnesium, mEq/L	2.14 ± 0.11	2.38 ± 0.05**
Inorganic Phosphorus Mg/dL	3.33 ± 0.07	3.83 ± 0.05**
Phenotypes: I	0	0
II	16	0
III	0	0
IV	4	13
V	1	0

*Mean ± S.D.
**$P < 0.01$

Results

Table IV presents the results of the lipids and serum ions that were analyzed on the 82 subjects. The mean serum cholesterol and triglycerides were slightly elevated in Phillipsburg as compared to Easton, but as can be seen from the table, the differences were not statistically significant. The total number of lipid abnormalities were also slightly higher in Phillipsburg, but also not significantly so. However, in Phillipsburg there were many more Type II lipoprotein abnormalities than in Easton, and in Easton there were many more Type IV abnormalities than in Phillipsburg. Despite the fluoridation of the water, the serum fluoride level showed no significantly different level for this parameter in the subjects of Easton. The serum lithium levels were also found to be essentially similar in the two communities. In the case of other ions measured, however, volunteers from Easton had significantly higher levels of serum calcium ($P<0.01$), serum magnesium ($P<0.01$) and serum inorganic phosphorus ($P<0.01$). This was particularly unexpected since the concentration of both calcium and magnesium was lower in the water from Easton than from Phillipsburg.

Discussion

The findings of similar blood cholesterol and triglyceride levels in both cities is not surprising in view of the similar diet patterns, the latter being confirmed by gas liquid chromatographic analysis of the fatty acids in the serum triglycerides. The chance finding of the larger number of Type II lipid abnormalities in Phillipsburg as opposed to Type IV in Easton probably is related to the relatively small sample size, and its exact meaning is not clear. From the results of this study it appears that the serum fluoride compartment is very labile and will not mirror long-term slightly increased fluoride ingestion. It suggests the need for finding some more sensitive parameter to monitor increased intake of fluoride. Since both water and diet were essentially similar in both areas, the finding of similar serum lithium levels was to be expected. The unexpected finding that the subjects from Easton had significantly higher serum calcium, magnesium, and inorganic phosphorus levels may be a reflection of a possible synergistic effect of fluoride in the absorption and transport of these three ions.

Summary

It has been noted that there is no difference in the age of specific heart disease mortality rates in the "twin cities" of Phillipsburg and Easton despite prolonged fluoridation of the water supply in the latter city. Since diet and environmental factors other than fluoridation appear similar, long term fluoridation does not appear to adversely affect cardiovascular disease mortality rates.

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45 Elm Street
(Dr. Fleischman)

Society Demands More from Men than from Women in Psychiatric Rehabilitation

Women have a definite advantage over men in re-entering society while coping with mental illness, says a report in a recent *Archives of General Psychiatry.* Society expects men to work at a job outside the home and earn a living, while it demands of women only that they maintain a reasonably good personal appearance and some social contacts, along with doing an acceptable job as housekeeper within the home, the study asserts.

The report from the University of Missouri and St. Louis State Hospital analyzes the records of 137 patients referred to a psychiatric rehabilitation program conducted in cooperation with rural Missouri towns.

The Missouri program, known as the Foster Community Project, was developed to serve chronic psychiatric patients who do not have the social and vocational skills for supporting themselves in the community and for whom nursing home placement or returning to their own families is inappropriate. The citizens of two small rural Missouri towns have been engaged in rehabilitating and placing patients with families or in apartments in their towns. "Female patients seem to have an advantage in this program. More women than men have been referred, accepted, and placed in the communities," says the report. Of the patients in the study 53 were men and 84 were women.

Only two female patients placed in the foster communities held regular jobs; the others have either not worked or have done odd jobs such as housecleaning and babysitting. In contrast, only those male patients who could be employed were accepted into the foster communities. If they could not find or hold a job, they weren't wanted.

Rather than contradicting the arguments presented by the advocates of the women's liberation movement, this supports the need for basing role expectations on individual preferences and abilities rather than sex.

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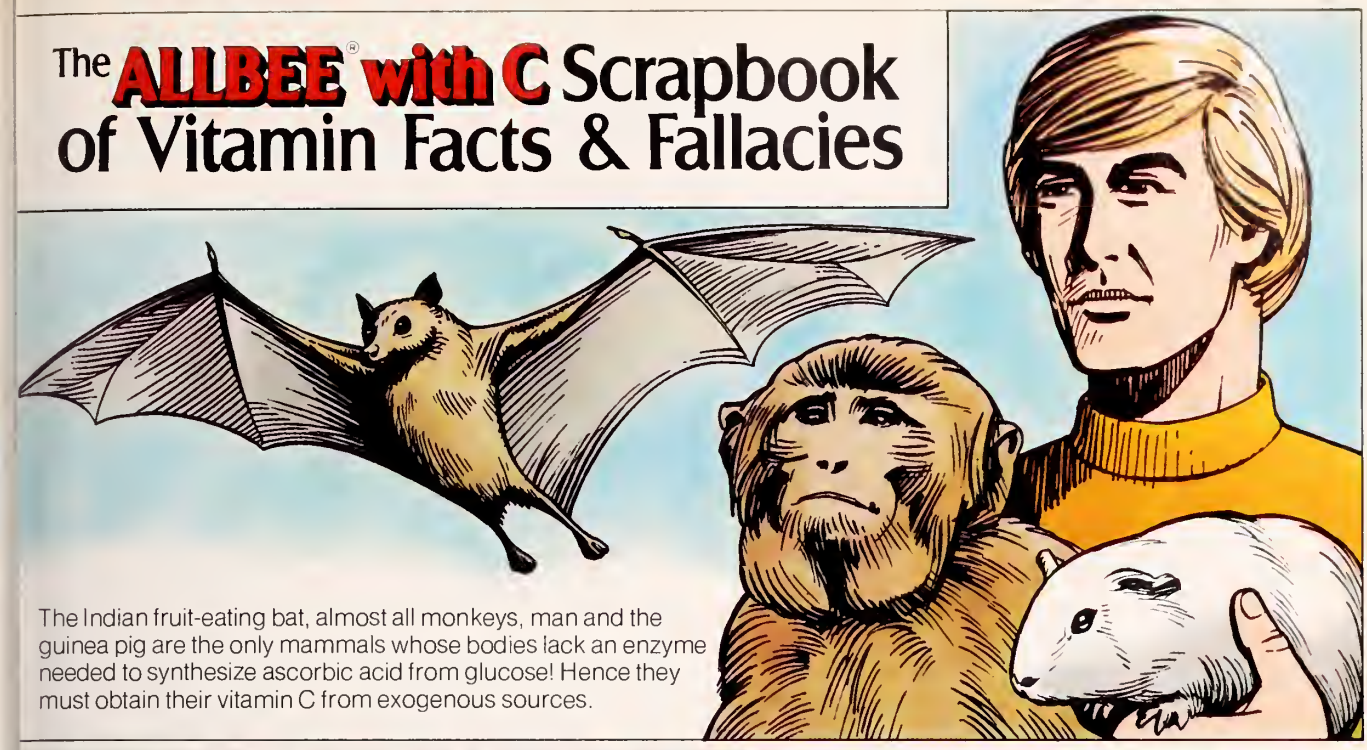
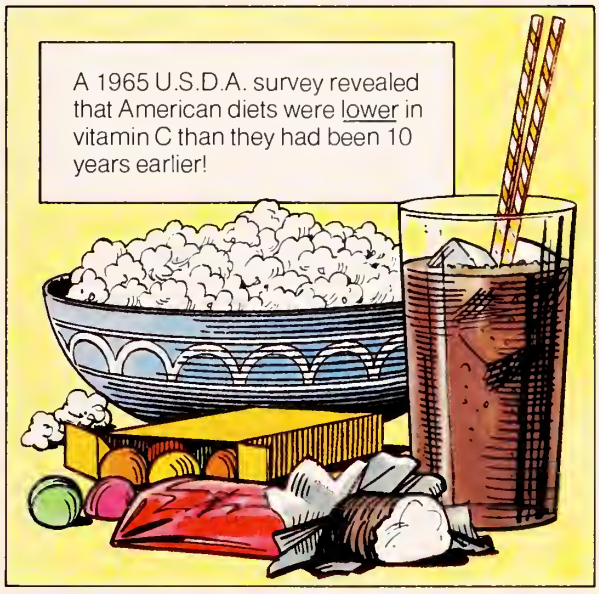


The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.

De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.



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Three hundred patients had primary sterilization by electrosurgical division of the fallopian tubes, through a laparoscope. Virtually all of the patients were hospitalized only a few hours and there were no complications.

Laparoscopic Tubal Sterilization*

A Review of 300 Consecutive Private Patients

H. W. Taylor, M.D./Pennsville

The history of laparoscopy began around 1901, but modern laparoscopic techniques are largely the result of recent advances in optics, illumination, and instrumentation. Further refinements are continuously being introduced.

Palmer, Steptoe, Fragenheim, Cohen, Semm, and others pioneered in the development of laparoscopy for both diagnosis and treatment. The use of laparoscopy to simplify female sterilization was among the later techniques developed, but it accounted for much of the recent enthusiasm in the United States. The great value of this method to improve the diagnosis of pelvic pathology and perform other operative procedures has been of equal importance, but has gained less publicity.

Heretofore, elective interval tubal sterilization has been accomplished by a major surgical procedure requiring a period of hospitalization and convalescence. Laparoscopic sterilization has permitted the use of out-patient techniques and typically causes little discomfort and disability. This has made the benefits of surgical sterilization available to women who must balance the desirability of such a procedure against the time which may be lost from their family or career obligations.

In southwestern New Jersey and northern Delaware, laparoscopy was started in early 1971. Since that time, the number of sterilizations by this method has increased rapidly. In mid 1971, approximately 25 of these procedures were being performed monthly at the Wilmington Medical Center (General Division). By mid 1972, this number had increased to about 150 a month and by mid 1973, with the start of laparoscopy at the Salem County Memorial Hospital, the combined figure had reached over 200 a month. The contribution of this large number of sterilizing procedures to a declining birth rate has been significant.

Materials

The material reviewed was a consecutive series of 300 private laparoscopic tubal sterilizations performed by the author at the Wilmington Medical Center (General Division) and the Salem County Memorial Hospital between December 1971, and July 1973. Diagnostic and other surgical laparoscopic procedures were excluded. For several months prior to the start of this series, various techniques of laparoscopy had been utilized in an effort to eliminate the problems of a new procedure, since inexperience has often been given as a reason for failure.[1] It was also planned to conduct a detailed study and follow-up of patients.

No patient was denied laparoscopic sterilization after appropriate explanation of the

*From the Department of Obstetrics and Gynecology, Salem County Memorial Hospital and the Wilmington Medical Center.

procedure. No requirements of age, parity, or marital status were applied. Consent of the husband was considered desirable, but not mandatory. No patient was excluded because of obesity, previous surgery, or medical problems, although specific contraindications to laparoscopy would have been observed if they had occurred. Physician referral accounted for 28 percent of these patients, many because of medical problems or lack of facilities in their own communities.

Age and parity are shown in Figure 1. Weight and previous contraceptive practice are shown in Figure 2. Previous abdominal surgery had been performed in 58 patients, including 22 who had major pelvic surgery.

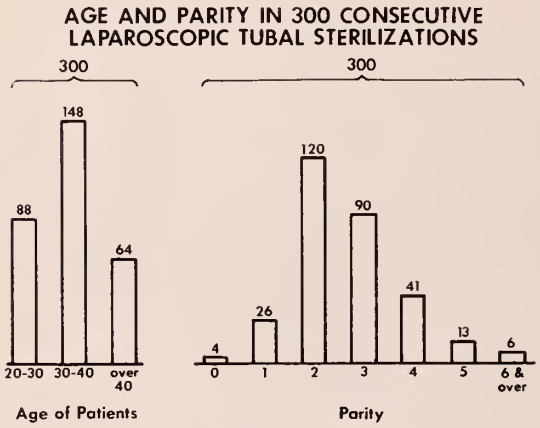

Figure 1

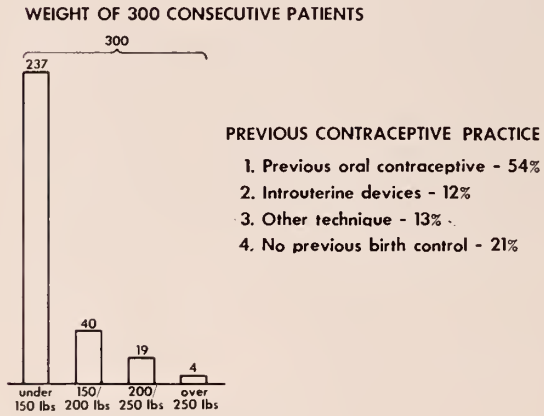

Figure 2

Various medical complications were present in 80 patients including 24 cases of hypertension, 5 of diabetes, 3 of rheumatic heart disease, 2 of multiple sclerosis, 1 of breast carcinoma, and 1 patient with previous severe back injury. None of these resulted in significant problems during the procedure although they often influenced the decision for sterilization.

Pre-existing pelvic pathology was observed at laparoscopy in 80 patients (27 percent). In some, the problems had not been recognized previously and will now require consideration in evaluating future health and complaints. Leiomyomata were present in 38, chronic salpingitis in 6, and endometriosis in 2. Adhesions and sizable varicosities made up the remainder. In one instance, a partially perforated Lippe's loop was found under the bladder flap.

Supplementary procedures were carried out in 128 patients. These included 89 D and C operations, 5 cervical biopsies, and 17 therapeutic abortions by aspiration techniques. All terminations of pregnancy were performed at the Wilmington Medical Center. The experience of the first few months following liberalization of the abortion laws indicated there will be an increase in the number of combined abortion-sterilization procedures. Typically, the pregnant patients in this series were somewhat older (34 years) and of a slightly greater parity (3.1 children). In 2 cases, pregnancy had occurred with an intrauterine device *in situ*. Three patients became pregnant despite the use of foam or condom, and in 12 cases birth control had not been used. Large series of these combined procedures have been reported.[2,3]

Technique

All cases in this series, except two diabetics, were performed on an out-patient basis. The pre-operative evaluation, including history, physical examination, and cervical smear, was performed in the office. Routine laboratory studies were usually obtained a day or two in advance of the procedure. About two hours before operation, the patient came to the hospital out-patient floor in a fasting condition.

She was seen by a member of the anesthesia department and pre-anesthetic medication prescribed. No enemas or shaving were used. Following operation, the patient was sent to the recovery room, and when responsive and stable was taken back to the out-patient floor. Discharge home was usually about three hours after operation. There appeared to be no medical advantage to hospitalization beyond this time period, although a few patients elected to remain overnight as a matter of convenience rather than necessity.

Various types of general anesthesia have been used, usually Pentothal® with nitrous oxide and oxygen plus Ethrane® or Sublimaze.® The question of intubation has been strictly a decision of the anesthesiologist; in practice, less than 10 percent of patients were intubated. Those with marked obesity were intubated. Recovery from anesthesia has been typically very rapid and uneventful. Very little postoperative sedation has been required.

In the operating room, following induction of anesthesia, the patient was placed in a modified lithotomy position. Catheterization and bi-manual examination were performed. The cervix was grasped with a tenaculum and a self-retaining cannula placed in the uterus. An incision of 0.5 to 1 cm. was made transversely in the lower border of the umbilicus and a Verres® needle inserted into the abdominal cavity, directing the point at a 45° angle toward the pelvic organs to avoid the great vessels. (Figure 3) After proper placement had been determined, the peritoneal cavity was insufflated with 2.5 to 3 liters of carbon dioxide using the Wisap CO_2 pneumoinsufflator. Special attention was given to gas pressure. In the author's experience, initial pressure over 10-12 mm. mercury usually indicate improper needle placement. Pressures are not allowed to increase over 15 mm. mercury. Careful monitoring of pressure along with a clinical appraisal of the degree of distention seems more important than the exact amount of gas used. The Verres® needle was then withdrawn and the laparoscope trochar and sheath inserted. The trochar was withdrawn and the laparoscope inserted.

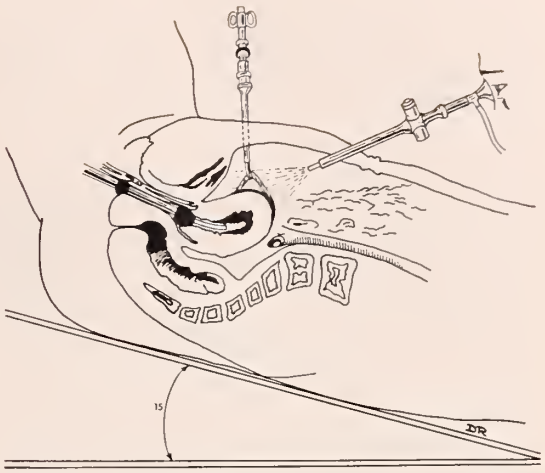

Figure 3—Typical cross section during laparoscopy.

Visualization of the pelvic organs should be excellent. A 10° to 15° Trendelenberg position causes the bowel to fall upward out of the pelvis. In the technique using only one puncture, the operating forceps were inserted through the same sheath as the laparoscope. In the two puncture technique, a separate forceps sheath was introduced under direct vision lower on the abdomen, slightly to one side of the midline. The uterus can be moved for best viewing by means of the cervical tenaculum and cannula which were previously placed.

The fallopian tubes must be carefully identified, preferably by visualization of the fimbriated ends. Each tube was grasped with the forceps about 2 cm. from the cornua of the uterus, slightly coagulated and the continuity interrupted or segments excised. By whichever technique, the cut ends of both tubes should be positively identified as being completely divided. A general examination of the interior of the abdomen can then be carried out. When the procedure was completed with verification of hemostasis, the laparoscope was withdrawn and the carbon dioxide allowed to escape slowly. The sheath was removed and the small incisions closed with sutures of 0000 Dexon.® Patients were instructed to telephone the following morning and usually were examined in two or three days to check their general condition and remove the small sutures. An appoint-

ment for a visit in four weeks was then made. No restrictions were placed on either general or sexual activity unless other procedures had been performed.

Various types of laparoscopes and forceps were used during this series. The one puncture technique was carried out in 49 cases, using both the Wolf and Storz operating laparoscopes. The two puncture technique was carried with the 10 mm. A. C. M. I. and Eder laparoscopes and electrosurgery performed with the A. C. M. I. biopsy forceps or the Eder-Palmer forceps. More recently a Wolf 5 mm. laparoscope has been used with excellent results.

Certain points of technique deserve emphasis. (1) There is a "feel" to the insertion of needles and tochars into the peritoneal cavity which may be lost if the operator makes undue efforts to produce upward traction on the abdominal wall. (2) Attention must be given throughout the procedure to the maintenance of an adequate pneumoperitoneum. (3) The forceps must grasp only the tube. Inclusion of any surrounding vascular structures is an invitation to hemorrhage. (4) The laparoscope must be drawn back sufficiently during coagulation so that the operator can visualize the entire operating area and eliminate any possibility of electrical contact between laparoscope and forceps. (5) The electrosurgical instrument must be under the direct control of the operator, who should have a knowledge of electrosurgical principles and the characteristics of his equipment. The lowest practical voltage setting must be used and if this is inadequate, the electrical connections and insulation must be carefully checked before higher settings are used.

Results

There were no immediate major operative complications in this series. All cases were completed successfully and without the need for laparotomy in any instance. Early in the series, bleeding occasionally occurred from the mesosalpinx, which was controlled by coagulation. More attention to proper forceps placement on the tube minimized this problem. There was one case of gastric distension due to improper intubation which was recognized and corrected. There were no other significant anesthetic, cardiac, or pulmonary complications.

A follow-up of at least four weeks was obtained in all but 16 patients. Some problems, usually minor, were found in the post-operative period. Ecchymosis below the umbilical trochar puncture was notable in 12 patients; in one there was a small amount of spontaneous blood drainage through the umbilical incision on the fourth post-operative day. Ecchymosis has not occurred since the 5 mm. Wolf laparoscope has been used. One patient experienced slight abdominal distension and a mild febrile reaction. Numerous patients complained of temporary shoulder or chest discomfort.

About four weeks after laparoscopic surgery, one patient developed right lower quadrant pain and was operated on elsewhere for suspected appendicitis. Another patient, in whom chronic salpingitis had been diagnosed at laparoscopy, developed a tender 5 cm. right adnexal cyst which was thought to be a hydrosalpinx. This resolved with conservative management.

No pregnancies have been reported subsequent to these laparoscopic sterilizations, however, the period of observation is not sufficient to make valid conclusions. The presence of a coincidental pregnancy was avoided by scheduling the procedure shortly after menstruation unless the patient was using a reliable contraceptive method.

Special effort has been made to follow the menstrual pattern in these patients postoperatively. Williams and Associates[5] and White[6] have suggested an increased incidence of menstrual disorders following tubal sterilization. However, the changes in menstrual patterns reported thus far by these patients seem mostly related to discontinuing other birth control methods. A decrease in menstrual discomfort and amount of flow was specifically

reported by 14 patients after removal of intrauterine devices. Prior to operation, a total of 16 patients had given a history of irregular menses. Following surgery, a total of 23 patients reported irregularity, but in nine of these the problem was confined to the first few cycles and occurred in patients who had taken oral contraceptives for several years. A longer period of observation will be required to interpret the significance of tubal sterilization on menstrual function.

Hysterectomy has been performed on three patients from the earlier portion of this series. One patient developed suspicious cervical smears, and showed a severe dysplasia on biopsy. One patient had increasing symptoms of pelvic floor relaxation and one continued to have dysmenorrhea associated with endometriosis. The latter problem had been diagnosed at the time of the laparoscopy.

No unusual psychological sequelae have been reported by any of these patients. None has expressed dissatisfaction with surgical sterilization in this short follow-up period. A later survey of psychological effects is planned.

Many techniques of laparoscopic sterilization fail to produce a specimen of tube for pathological study, however, a small segment is obtained by using the A. C. M. I. forceps. Of the 468 segments submitted for analysis during this series, 232 were positively identified as fallopian tube and 236 were reported as "suggestive" or "probable." It is important to recognize the difficulty experienced by the pathologist in interpreting these small and partially coagulated specimens.

Discussion

It would be inappropriate to suggest that the absence of serious operative complications in this limited series could necessarily be maintained in a large number of patients. The report of the Complications Committee of the American Association of Gynecological Laparoscopists in November 1972, indicated a 0.6 percent major complication rate. It is hoped that more thorough training will result in a reduction of this figure.[7] Although uncommon, certain complications such as abdominal wall hematoma formation seem nearly unavoidable even in the hands of a skilled laparoscopist.[4]

One of the most challenging technical problems has been the need for a safe and dependable method for interruption of the fallopian tubes. Since the use of spring clips and certain other techniques have proved relatively difficult or unreliable, electrosurgery has been the major method in use throughout the world. However, the potential hazards of intra-abdominal electrosurgery are obvious and it has required close cooperation between physician and the manufacturer to reduce these risks.

Wheeless and Thompson[8] report ten cases of electrocoagulation of the gastrointestinal tract in 3600 cases. Rioux[10] reported three electrocoagulation complications in 1000 cases. Burns of the skin and iliac artery have been reported.[7]

Improved insulation of instruments and the use of nonconductive sheaths has offered only a partial solution. High voltage, high frequency current may behave in an unpredictable fashion with the possibility of dissemination across the moist tube and mesosalpinx to surrounding vital structures. Improved designs of electrosurgical units with isolation from ground are now available. They avoid the danger that current will seek an alternative pathway to ground. These units are also capable of delivering a more predictable current at a lower voltage than the traditional Bovie spark-gap unit.[9] Rioux[10] has designed a true bi-polar electrode which should be available soon. Semm[11] recently reported the use of controlled low frequency current. It seems likely, therefore, that electrocoagulation injury will be minimized as a complication in the future.

In reviewing these statistics, especially in regard to those patients (27 percent) who had pre-existing pelvic pathology, the question should be raised as to whether some would

not have been better treated by hysterectomy. At times this was proposed to patients, but they were not prepared for a more extensive procedure, and their immediate need was being fulfilled by the sterilization. Their knowledge of the laparoscopic findings seems to make it easier for them to accept the thought that future surgery may be necessary.

Although the concept of detailed counseling for sterilization is important,[12] the patients in this series seemed highly motivated and secure in their decision. Relatively more counseling was given to younger patients and those of low parity. Counseling must include a discussion of the fact that laparoscopy is a sophisticated surgical procedure which is not entirely free of risk. The permanence of the procedure using present techniques must also be considered since satisfactory repair of tubes after electrosurgical destruction awaits evaluation.

The safety and effectiveness of laparoscopy can be increased by a team approach. The operating room staff should be familiar with the proper maintenance and handling of instruments. Recovery room and out-patient nurses must be able rapidly to distinguish important problems in the postoperative recovery pattern. Since the hospital contact during out-patient laparoscopy is brief and intense, complete familiarity with both physical and psychological support of the patient is important.

Summary

A review of 300 consecutive laparoscopic tubal sterilizations is presented. The background of procedure and patients is discussed. Pre-existing pelvic pathology was noted in 27 percent of patients. Laparoscopic technique is described and the potential hazards of intra-abdominal electrocoagulation are discussed. All cases in this series were completed successfully without need for laparotomy. There were no major complications. A follow-up of the patients is presented. Laparoscopy is a sophisticated surgical procedure which should only be performed by a qualified surgeon in a proper hospital environment. Under these conditions, the advantages justify its rapidly increasing popularity.

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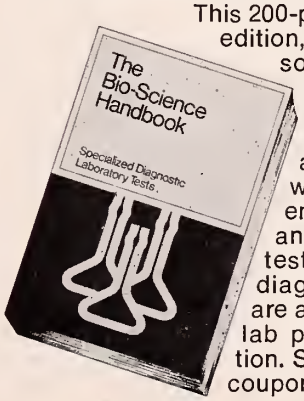

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The complex role of the physiatrist, as a specialist and team coordinator, has not been adequately recognized. Illustrative areas of activity with stroke patients, cardiacs, and amputees are described. Cost control, awareness of new operative procedures, and other facets of rehabilitation medicine are unique to the physiatrist.

The Role of Rehabilitation Medicine in the Delivery of Health Care

Heinz I. Lippmann, M.D.
West Englewood

The specialty of Rehabilitation Medicine (physiatry, physical medicine and rehabilitation) has developed because conventional therapy and medical resources had proved inadequate in dealing with the disabled or handicapped, whose mobility, ability for self care or communicative skills were impaired as a result of congenital defect, injury, or disease. Like all clinical disciplines, physical medicine and rehabilitation is concerned with prevention, diagnosis, and treatment. In addition to the traditional *prevention* of diseases, however, physiatry aims at minimizing secondary disabilities which may result from preventable or treatable conditions, such as flexion contractures, pressure sores, muscle or bone wasting, organic or psychologic alienation, to name a few. Physiatric *diagnosis,* beyond the search for pathogenesis and etiology, concerns itself with an assessment of residual function and the potentialities for functional improvement. Estimation of muscle strength and coordination, respiratory, cardiac, and vascular reserve are random examples of such assessments. Physiatric diagnosis also includes an inventory of the patient's abilities and skills, needed for optimal functioning in his usual environment. Physiatric *management* concerns itself mainly with designing and implementing a workable plan for restoration. The realization of such a plan often challenges the combined experience and action of a group of health professionals (physical therapists, occupational therapists, social service workers, speech therapists, rehabilitation counselors, nurses) whose cooperation, under the supervision of the responsible physiatrist, may bring about best results. In some cases the plan may have to include the services of a plastic or neurologic surgeon, an orthopedist, urologist or other medical specialists.

The physiatrist shares with the psychiatrist an interest in human motivation and in defense mechanisms against health threats. Like the social scientist, he is concerned with the role of the family and society in the reintegration of the disabled into his usual habitat.

Thus, the body of knowledge with which the physiatrist must be familiar is acquired by no other clinical specialist. While the physiatrist shares some knowledge with almost all medical and surgical specialties, he often looks at a patient from a different point of view. As an example, the neurologist assesses motor or sensory loss to locate and to define a lesion, while in the same patient, the physiatrist tries to take stock of the motor and sensory *residuals* in order to work out a plan with the patient to minimize disability and dependency. In gaining his special expertise today's

Dr. Lippmann is Professor of Rehabilitation Medicine at the Albert Einstein College of Medicine of Yeshiva University, Bronx, New York.

physiatrist has become a specialist in prosthetic and orthotic devices, manual and electric testing of neurologic or muscular deficits, functional restoration of the stroke patient, reintegration of the cardiac patient to society, management of the neurogenic bladder, conservative handling of peripheral vascular diseases, reactivation of the arthritic patient, functional restoration of the amputee, and aiding the young patient with congenital or acquired musculo-skeletal disorders and his family. He has also become expert in group practice and in using professional and community health resources to the benefit of the patient. This incomplete list is lengthening every year with the increasing prevalence of chronic disabling disorders which represent the main health problems of our advanced technological society. Clearly, the physiatrist of tomorrow is destined to play a key role in the delivery of health care in the near future in any system which considers the welfare of the patient. In this paper his role in three arbitrarily chosen areas of health care will be discussed: the management of the stroke victim, the cardiac, and the amputee.

The Need for Rehabilitation of the Stroke Patient

Every year some 600,000 individuals in the USA suffer a stroke. Approximately 500,000 of these will survive long enough to regain some function. Of these patients, 50,000 will emerge virtually unimpaired; 200,000 will have mild residual disability; 200,000 will require special care and some 50,000 will require institutional care.[1] All of these will benefit from rehabilitation procedures, perhaps with the exception of some in the first group. The last two groups will need long-term rehabilitation care.

Rehabilitation programs, if initiated early, are best carried out by a group of health professionals. They are planned for each patient, according to a projected rehabilitation potential which depends on the patient's state of mentation, his residual function in areas of deficit, the nature of this deficit, the residual capacity to communicate, and his general condition. The goals of rehabilitation for the patient are optimal levels of independence, of communication, of mobility and of reintegration into his usual environment.

While the mildly disabled patient can be treated at home or on an ambulatory basis, and rarely offers a challenge to the physiatrist, rehabilitation of the severely disabled such as the hemiplegic child, the young adult stroke victim, or patients with cerebellar or bilateral cerebral involvement, extreme spasticity, or prolonged flaccid paralysis is often complicated.

Studies concerning the life expectancy of stroke patients reveal survival rates of 30 to 60 per cent after one year, 15 to 40 per cent after five years, and 20 to 30 per cent after eight years. Of patients who have survived for six months following a stroke, 35 to 40 per cent are alive after eight years. Some 50 per cent of acute stroke victims are alive after six months and half of this group is still alive after five years. On that basis, health and maintenance care should be planned for approximately 75,000 stroke victims each year who will be alive five years—and many even ten years—after the stroke.[2]

Health care, has changed spectacularly along technological lines, such as revascularization procedures and organ transplantations, while the dramatic virtuosities of the modern hospital center provide spectacular benefits for the desperately sick who are relatively few. Our government, allegedly concerned with giving an equal opportunity for healthy living to each individual, has in fact been giving precedence to expensive and dramatic health care and therapeutic procedures which lend themselves to easy cost accounting. Unfortunately, relatively inexpensive measures of health maintenance which can bring large benefits to the stroke victim have fared badly under Medicare and Medicaid.

Few of the partially or completely dependent stroke patients can return home; while many must be taken care of for the rest of their lives in an extended care facility or a nursing home. Among those partially or totally inde-

pendent who must live away from their families, most can board with other people or live in less costly quarters. Thus, the yearly cost of care correlates with the degree of dependency.[3] A totally dependent stroke patient who needs total nursing care, is non-ambulatory, has a non-functional hand, marked impairment of communication, medical complications, or psychological disturbance may live for eight years at a cost of $25 to $30 per day, i.e., from $9,000 to $11,000 a year.

The partially dependent stroke patient (who is ambulatory with aids, may have a non-functioning hand, has moderate impairment of communication, reduced judgment or initiative, has no serious medical problems, and needs assistive partial nursing care) can be maintained for a yearly $6000. The partially independent mentally and psychologically intact stroke patient (who is ambulatory on a reduced scale, may have some reduction in hand function, mild impairment of communication, and needs minimal assistive care) can be maintained for $3,600. The totally independent stroke patient (who can return to his usual activity, in spite of some hand and walking impairment, and who needs no assistance) can live away from his home for $2,400 a year.

The acceptance of a stroke patient by his family correlates with his capacity for self-care. The hospitalized patient loses his place in the family surprisingly fast if his return would force family members to give up a job. The patient's psychological adjustment and self-image will largely be determined by the capability for self-care. In discussing the maintenance cost of stroke patients, specific areas of dependence must be recognized. For instance, maintenance for the patient who has learned to eat without help, will save some $2,300 a year in a nursing home. In this, as in other functions, minor improvement or return of function may be of great benefit. Most published follow-up studies of stroke patients, who have been subject to rehabilitation care early after their insult, report that only 3 to 5 per cent remain totally dependent.[4] Conversely, it is estimated that some 75,000 patients in the United States receive inadequate rehabilitation care, resulting in self-care dependence. Simple but essential tasks, such as hair combing for women, unassisted transfer from bed to wheelchair and vice versa, toileting, and self-feeding, may be lost to the patient who had no rehabilitation care. Irreversible flexion contractures, pressure sores, disuse atrophy, orthostatic problems, venous ulcerations, can all be prevented by early rehabilitation care. All of the disabling results of rehabilitative neglect will impose a burden on the patient, on his family and, because of the increased cost of maintenance, on society. Medicare pays only for restorative services but not for stroke maintenance care, an item of relatively small cost. The national cost reduction, attainable by rehabilitating the stroke patient to move up only one category—from dependent to partially dependent—has been estimated to amount to $1.38 billion a year.[5]

The function of the physiatrist, from this point of view alone, needs no further comment. Rehabilitation care should be part of modern management of the stroke patient and an integral part of every community hospital program.

Cardiac Rehabilitation

Rehabilitation of the cardiac, in addition to the traditional care rendered by the primary physician or cardiologist, includes an ongoing estimation of cardiac reserve and cardiac excitability, both of which may change with the healing of the infarct. The formulation and implementation of cardiac rehabilitation includes exercise training programs designed to enhance cardiorespiratory endurance as well as guidance for safe activities of daily living, and, where possible, vocational counseling may also be included.

During the acute stage of a myocardial infarction, a knowledge of the caloric equivalents of bedside activities is a useful guide for prescription of positioning and gradual activities;[6] this technique has become a part of good nursing care. The patient with myocardial infarction after resolution of the acute stage, the patient with angina, and occasionally the

patient in heart failure may benefit from exercise training. Training programs are individualized and formulated according to the results of tests of the patient's cardiorespiratory tolerance for isotonic exercise,[8] (exercise entailing body movements), e.g. walking, swimming, some gardening activities.[7]

During testing, the pulse rate and the earliest electrocardiographic manifestations of arrhythmia or ischemia are used as safety monitors. A pulse rate consistent with sinus rhythm, in the steady state, when oxygen supply and utilization are in balance, correlates with energy consumption.

Isometric exercises, which are more stressful to the cardiovascular system for each equivalent of energy consumed, increase muscle strength rather than endurance.[9] Weight lifting, shoveling, or other physical activities which are done with little or no body movements are not advised for the cardiac.

The Bergen County Cardiac Rehabilitation program, which was developed by Dr. Irving Levitas at Hackensack Hospital, is an example of the rehabilitation management of the cardiac which is rendered to some 500 patients every year.[13]

The following case report will illustrate some of these points:

A 76-year-old male had diabetes since 1953. He was inadequately controlled with oral hypoglycemic drugs. He had a permanent colostomy after abdominoperineal resection for rectal carcinoma. Transient ischemic attacks started in February, 1972. Right foot gangrene developed resulting in right below-knee two-stage amputation in April, 1973. Trifascicular heart block was discovered in May, 1973; insertion of a temporary and later of a demand pacemaker in June, 1973. Gangrene of left heel started in May, 1973 unrelieved by left lumbar sympathectomy or local treatment. Left below-knee amputation in July, 1973. After healing of both leg stumps patient was anemic (10.3 gm% Hgb), was in heart failure and had severe dyspnea after only mild exertion in bed. He was unable to transfer from bed to wheelchair, and developed wheezing, severe dyspnea and occasional hypotension, and dizziness after mild exercise. Pacemaker operated at rest. Exercise safety by testing was established at 1.5 Cal/min peak effort, which gradually rose to 3 Cal/min in this training program. Resting blood pressure was at 120/70 mm Hg. He received prosthetic ambulation training and later easily tolerated pulse rises to 120/min and blood pressure of 170/100 during exercise with return to resting values after four minutes. He had no more signs of cerebrovascular insufficiency, and was discharged to his home as a prosthetic ambulator, with the aid of a cane.

Rehabilitation Management of the Amputee

Eighty-five per cent of all amputations performed in the United States during peace time are the result of complications of arteriosclerosis obliterans and diabetes mellitus in the elderly. Surgical mortality has decreased in recent years, because of control of infections, and the preference for amputations below the knee. It is well accepted by now that impaired circulation (e.g., femoral or iliac artery occlusion), old age, neuropathies, blindness and heart failure, rarely contraindicate below knee amputations. Prosthetic rehabilitation is possible in most patients, who retain a functional knee; re-amputation at higher levels is rarely necessary. Successful newer amputation techniques are described in considerable detail in the literature.[10]

A new method of providing an amputation stump with a rigid dressing was introduced into this country in the early sixties. This technique, which permits almost immediate weight bearing on the stump, affords obvious physical and psychological benefits to the amputee. Some prefer to delay weight bearing until after healing of the stump, but healing time and hospitalization are cut short by the rigid dressing and "early" fitting procedure, which represents a marked advance in the management of the amputee.[11]

This program requires a group of health professionals to implement and time the various steps of this plan in cooperation with the patient.

In addition to a surgeon experienced in the special operative techniques, the team includes a specially trained physician (who may be the surgeon himself, a physiatrist, or other physician), a limb maker, a physical therapist, a nurse, and the patient himself. Planning and implementing a prosthetic rehabilitation and ambulation program is the physiatrist's responsibility. Such a program should include

a follow-up clinic, where the clinical management and education of the patient may continue, as well as training of the physician, nurses, and therapists. There are 400 such centers in the United States. The Inter-Society Commission for Heart Disease Resources,[12] emphasizes that amputee consultation services should be developed on a community level and on a regional basis; the latter could serve as an advisory board in case the level of amputation is in doubt. Thus, the physiatrist's role of planning and implementing an effective prosthetic rehabilitation program is a natural one on the amputee team.

Summary

The beneficial role of the rehabilitation specialist in the delivery of modern health care appears more established than recognized. Rehabilitation management of the stroke victim, the cardiac, and the amputee serve as examples to demonstrate the wide scope of rehabilitation management for the physically disabled.

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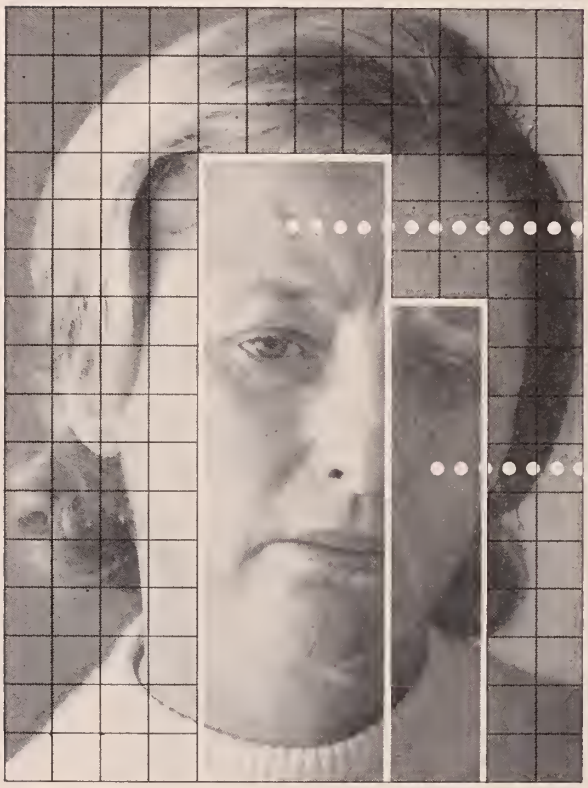
597 Sunderland Road

Karate and Liver Damage

A karate chop may be highly dangerous to your liver. John Davis Cantwell, M.D., and James T. King, Jr., M.D., of Georgia Baptist Hospital, Atlanta, describe a 39-year old woman who suffered severe liver damage from a combination of blows to the abdomen during her second lesson in karate. She suffered pain at the time. Six weeks later she was hospitalized. Surgery revealed the liver was lacerated and swollen to twice normal size. The damage was repaired and she recovered, after three weeks in the hospital.

The liver ranks second only to the spleen as the organ most commonly injured by a sharp blow to the abdomen. Death rate is high if treatment is delayed. In the case reported, the severe symptoms did not show up until six weeks after the injury. Early surgery and treatment are generally recommended for suspected liver injury. "This is not to condemn karate but rather to call attention to the potential injury to an abdominal organ from a forceful blow. Closer supervision of participants is advised," they conclude.

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent to the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
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Valium® (diazepam)

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in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The development and use of a peer review system is described. Evaluating forms are included.

Special Article

The Development of an Evaluation System for House Staff and Attendings

Leon G. Smith, M.D., Director of Medicine, St. Michael's Medical Center, Newark

For the past 13 years, Saint Michael's Medical Center has been striving to develop a comprehensive and effective system of evaluating attendings, residents, interns, and medical students. The purpose of this paper is to share these systems, forms, and problems with other medical centers so that we can begin to discuss these topics regionally for improvement on the local scene. Prior to 1963, there were no evaluation systems at all on attendings. Also, it was difficult to find any letters of criticism or recommendations on interns or residents. Consequently, in 1964 the attending physicians began to evaluate the house staff at departmental meetings. These evaluations were nothing more than concise statements by attendings as to an individual's strengths and deficiencies.

Subsequently, a special form was developed at Saint Michael's Medical Center to evaluate the house staff (Chart 1) and in 1965 it was mailed to the attendings who were on service for the month. These forms contained ratings of each house officer and student on service for that particular month. At first, the attendings were reluctant to mail these forms back for our record keeping, but with education and time they finally consented. Eventually, evaluations became a simple process.

The system was then updated to include history taking and physical examinations. These more detailed forms (Chart 2) were recommended by the American Board of Internal Medicine. In checking the validity of these evaluations, however, we found that only a few attendings actually observed interns and residents doing a history and physical. The situation was soon corrected. At the present time, our system of evaluating interns and residents is working nicely. For the past two years, these written evaluations have been made available to the house staff along with their entire file. Prior to this, evaluations had been kept secret, although the director of the department of medicine would orally summarize the attendings' evaluations to the house staff.

Chart 1

St. Michael's Medical Center
Newark

Name of Intern/Resident _____

Date _____

Service _____

Attending _____

	Superior	*Good*	*Satisfactory*	*Not Appraised*
Fund of Knowledge				
Common Sense				
Quickness of Thought				
Industriousness				
Reliability				
Technical Proficiency				
Curiosity				
Interpersonal Relations				
Poise				

To the attendings: Please complete the above and return to the Department of Medicine. Thank you.

It was extremely difficult getting the house staff and medical students to evaluate the attendings. From 1963 to 1965, these evaluations were done at the end of the academic year by the house staff members who were leaving this institution. The house staff feared they could be intimidated and their careers harmed by these criticisms. These fears disappeared with the appearance of a new "breed" of student and an increased number of American house

Chart 2

St. Michael's Medical Center
Newark

Name of Intern/Resident _____

Date _____

Service _____

Attending _____

History taking:

Evaluate the candidate's ability in history taking:
Outstanding____ Good____ Satisfactory____ Doubtful____ Unsatisfactory____ Comments:

Physical Examination:

Evaluate the candidate's ability in physical examination:
Outstanding____ Good____ Satisfactory____ Doubtful____ Unsatisfactory____ Comments:

Case Presentations:

Evaluate the candidate's ability to present cases:
Outstanding____ Good____ Satisfactory____ Doubtful____ Unsatisfactory____ Comments:

Record Keeping:

Evaluate the candidate's ability to keep medical records:
Outstanding____ Good____ Satisfactory____ Doubtful____ Unsatisfactory____ Comments:

Patient Management:

Evaluate the candidate's ability to evolve a meaningful plan for patient management:
Outstanding____ Good____ Satisfactory____ Doubtful____ Unsatisfactory____ Comments:

Rank the candidate's overall clinical competence:
Outstanding____ Good____ Satisfactory____ Doubtful____ Unsatisfactory____ Comments:

staff. By 1968, the house staff had become over-critical in their evaluations, and these group sessions thereby became a "sham."

Therefore, we instituted a monthly evaluation form (Chart 3), which became extremely valuable, expecially with respect to the attendance and punctuality of the attendings. At the end of each year, the house staff was allowed to choose the attendings for rounds for the following year, based on this evaluation technique. This system has up-graded the quality of teaching considerably with better "rounding." Each attending receives a copy of his evaluation by the house staff, students, and the director of the service.

Another program that we have initiated is the evaluation of our conferences. First of all, the education department developed a conference evaluation (Chart 4). Most of those who attended the conference will submit at the end of the teaching session their evaluation. We have unsuccesstully attempted to get an evaluation of the audience by guest lecturers. Written and oral tests have been rejected by both

Chart 3

St. Michael's Medical Center
Newark

Attending Evaluation

Month _____

Attending Physician _____

Intern or Resident _____

1. Frequency of attendance (by days per week) _____
2. Hours per day _____
3. Interest in teaching _____
4. Availability for discussion of problems outside the normal attending time _____
5. Do you think the attending should be continued in the teaching program _____
6. Additional comments _____

Chart 4

St. Michael's Medical Center
Newark

Dear Doctor:
In keeping with the A.M.A. accreditation requirements, it is necessary that you complete this form at the end of this meeting.

Participants' Conference Evaluation

Name _____ Date _____

Address _____

Topic _____ Time _____

Speaker _____

	Excellent	*Good*	*Fair*	*Poor*
Quality				
Learning Experience				
Topic Pertinent				

Suggestions: _____

_____

List the Most Important Points Learned: _____

the conferees and lecturers. Several medical educators have suggested that we try to increase our attendance at conferences by:

1. Having top-quality guest speakers.

2. Having active participation with each service presenting its own cases.

3. Presenting problem patients within the hospital (as was done in the grand rounds from yesteryear).

Even though we have obtained AMA recognition award credits for each of the conferences, and have placed a 50 percent mandatory attendance on our attendings, the attendance and participation are still mediocre. Overall, because of the evaluating system, the *quality* of our conferences is better but the attendance has not improved.

In 1973 we instituted house staff-peer evaluations. Interns evaluate residents; residents evaluate interns; and medical students evaluate both and vice versa. In essence, these evaluation forms (Chart 5) are similar to the ones used by the attendings evaluating the house staff. So far, we have had great difficulty in getting candid evaluations. One can get an *oral* evaluation, but there is extreme reluctance of these groups to evaluate each other, even though they consider themselves "open." To assist us in the peer evaluation, at morning report, all admission cases are reviewed in a general way and criticisms of handling the cases are given by both those who worked up the case and by those participating in the conference. This system has been helpful in peer evaluation but overall this method needs further development and exploration.

In summary, we have presented a concise history of our system of evaluating attendings, house staff, medical students, and conferences. The forms developed are workable, but many difficulties still need to be worked out.

Chart 5

St. Michael's Medical Center
Newark

Name of Intern/Resident/Student _____
(Circle level of training of person evaluated)

Date _____

Service _____

Evaluated by _____
(signature & year of training)

	Superior	*Good*	*Satisfactory*	*Not Appraised*
Fund of Knowledge				
Common Sense				
Quickness of Thought				
Industriousness				
Reliability				
Technical Proficiency				
Curiosity				
Interpersonal Relations				
Poise				
Presentation of Cases				
Appearance				

Please list below areas which need special help.

The Old Helping Hand Organization

Many of the younger doctors do not know that there exists in our state a unique helping hand organization, known as the Society for the Relief of the Widows and Orphans of Medical Men in New Jersey. This organization provides immediate financial assistance to the dependents of a deceased member. It lends money without interest to assist widows and orphans of doctors who have known adversity.

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In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

July 21, 1974

A regular meeting of the Board of Trustees was held on July 21, 1974, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Health Professions' Education Advisory Council . . . Reappointed Dr. William J. D'Elia as MSNJ's delegate to the Health Professions' Education Advisory Council and referred to the President and Chairman of the Board the appointment of an alternate. (Dr. George L. Benz requested that he not be reappointed.)

Multiphasic Health Testing Programs . . . Directed that opinion from the Office of General Counsel of the AMA concerning unsolicited multiphasic health testing reports be referred to the Council on Medical Services for study and recommendation of stronger guidelines to be used by physicians, and that the AMA opinion be widely disseminated, noting that it is currently under study by the Council.

Countersigning of House Officers' Hospital Orders—Temporary Limited License . . . Received a report on a meeting of representatives of MSNJ, CMDNJ, the New Jersey Hospital Association, the Department of Higher Education, and the State Board of Medical Examiners to discuss Resolution #19 (Countersigning of House Officers' Hospital Orders) and Resolution #33 (Temporary Limited Licensure) which resulted in the Board of Medical Examiners indicating they would consider a proposal for provision of a temporary limited license to house staff for the first eighteen months of their training period after which they would be expected to become regularly licensed (a policy prevalent throughout the country).

Press at House of Delegates Sessions . . . Referred the following recommendation from the Committee on Annual Meeting to the Council on Public Relations for consideration and report, noting that the AMA House of Delegates is open to members of the press:

> That, beginning in 1975, members of the press displaying official badges be admitted to the sessions of MSNJ's House of Delegates.

Umbrella Major Expense Rider . . . Approved the following recommendation from the Committee on Medical Defense and Insurance:

> That the Board of Trustees approve the Umbrella Expense Rider extending Major Expense Policy Coverage to $150,000 as presented by the E. and W. Blanksteen Agency.

AMA Annual Convention . . . Approved, with commendation, a report from the New Jersey Delegation to the AMA Annual Convention which highlighted the following:

Physicians and the Government

PSRO's—Speculation over possible changes in PSRO policy by the House dominated the attention of those attending the convention, including the media.

During its day-long hearing on Monday, June 24, Reference Committee "A" considered two reports and 25 resolutions bearing on the issue, and estimated that 64 speakers addressed themselves to PSRO.

But on Wednesday, the Delegates—cognizant of the hours of debate devoted to PSRO at Anaheim last December and in New York City last June—overwhelmingly voted (202 to 24) to terminate debate after a few minutes.

Then the House adopted a substitute resolution on PSRO proposed by the reference committee, whose members emphasized that the resolution provides the association with a "clear-cut, definitive position which cannot be misunderstood by anyone inside or outside this House of Delegates." The resolution:

> Instructs the Board of Trustees to seek constructive amendments to the PSRO program, particularly in potentially dangerous areas such as confidentiality, malpractice, development of norms, quality of care, and the authority of the Secretary of HEW.
>
> Directs the AMA to continue efforts to achieve legislation which allows the profession to perform peer review according to established medical philosophy and the best interests of the patient.
>
> Emphasizes that state associations which elect non-

compliance with PSRO are not prevented from doing so by the new policy, but urges such associations to develop effective non-PSRO review programs embodying the principles endorsed by the profession as constructive PSRO alternatives.

The new policy also provides that in the event that the PSRO program does, in fact, adversely affect patient care or conflict with AMA policy, then "the Board of Trustees (will) be instructed to use all legal and legislative means to rectify these shortcomings."

Extension of Policy on National Health Insurance—Two statements on national health insurance were adopted after lengthy debate. One calls on the Board of Trustees to cooperate with state associations "to attempt to devise mechanisms mutually acceptable to the private medical and insurance communities which will ensure the provision of health insurance coverage through the purchase of private health insurance, and to seek means to secure favorable Congressional and public support for their adoption."

During discussion, it was pointed out that the addition of the NHI policy does not affect AMA support for Medicredit, but is intended to stimulate new health insurance mechanisms. The second resolution calls on the AMA and component associations to work to detach "any national health insurance program from the controlling intrusions of existing PSRO laws and regulations."

Oppose "Public Utility" Medicine—The House went on record as being opposed to certain bills in Congress which would replace the federal "Health Professions Educational Assistance Act" which expired June 30. Under the bills, comprehensive health planning programs would be replaced with public utility type bodies which would control certain aspects of health education and health care delivery, and medical licensure. An amended resolution adopted by the House directs the Board of Trustees to mobilize AMA membership in opposition to offensive sections of the proposed legislation, and take strong actions on other fronts.

In other actions affecting physicians and the government, and other third parties, the House:

Requests the AMA to work with third parties to secure increased acceptance of the AMA uniform health insurance claim form, and urges state associations to encourage acceptance of the form by insurance commissioners, and, if necessary, through state legislation.

Urges continued AMA efforts to prevent future imposition of government fee controls, and opposes the mandatory imposition of a "health-card" as the payment mechanism under the Administration's national health insurance plan, and instead, reaffirmed the right of the physician to bill patients directly.

In other actions affecting physicians and the public, the House directed that:

The new national blood policy be privately implemented through the appropriate organization of the AMA, state, and county medical societies, and their committees on transfusion.

The AMA continue to inform the public and the profession of the potential problems and risks in permitting the non-physician substitution of drugs of choice prescribed by physicians, and that state associations support this position before state legislatures considering laws which would allow drug substitutions.

The AMA endorse use of the condom as one of the effective methods of venereal disease control.

Physicians and Hospitals and Medical Schools

Report on Physician-Hospital Relations, 1974—The House adopted the 104-page "Report on Physician-Hospital Relations, 1974," compiled by the Council on Medical Service and its Committee on Private Practice. An update of an earlier report made in 1964, the 1974 version contains 14 specific recommendations to cope with problems developing between some hospitals and their medical staffs. Among other things, the recommendations are aimed at protecting medical staffs against unilateral action by hospital governing boards relative to staff bylaws, rules, and regulations.

Association and Internal Matters of the House

Specialty Representation in the House—In response to proposals to increase specialty representation in the House, the Reference Committee on Constitution and Bylaws reported extensive testimony, and urged "all concerned parties to increase communication, cooperation, and liaison" to resolve the complex question.

Disposition of MSNJ Resolutions Presented to AMA House

1. *Joint Commission on Accreditation of Hospitals Due Process For Physicians Employed in Medico-Administrative Positions—Resolution #84—A-74*

This Resolution was considered together with Resolution #22 (A-74), which was of a similar nature. The AMA House of Delegates adopted the following substitute resolution in lieu of Resolutions #22 and #84:

That the recent interpretive language of Standard 8 of the Governing Body and Management Section of the *Accreditation Manual for Hospitals* that concerns due process for physicians employed in medico-administrative positions be referred to the AMA Commissioner to the Joint Commission on Accreditation of Hospitals and the Joint Commission on Accreditation of Hospitals itself for further study and comment.

2. *Recultivation of the Poppy—Resolution #23—A-74*

This Resolution was not adopted because of the "sensitive political ramifications on an international scale" and conflict with the AMA policy "to take all measures necessary . . . to insure that an ample supply of opium and its derivatives are made available to the medical profession."

3. *Federal Catastrophic Health Insurance—Resolution 95—A-74*

This Resolution was combined with Resolution #47—A-74, sponsored by the California delegation and subsequently amended. The final adopted "resolved" reads as follows:

That the AMA Board of Trustees immediately in concert with state associations attempt to devise mechanisms mutually acceptable to the private

medical and insurance communities which will insure the provision of health insurance coverage through the purchase of private health insurance; and seek means to secure favorable Congressional and public support for their adoption.

New Jersey Hospital Association . . . Approved a report from Dr. John S. Madara, MSNJ's liaison to the New Jersey Hospital Association, on a July 12, 1974 meeting of the Board of Trustees of NJHA.

. . . Directed that NJHA be informed of MSNJ's positions on S-903, A-1257 and A-1332 and our reasons therefor.

. . . Directed further that a strongly worded communication (to be drafted by the President, Chairman of the Board, and Executive Director, in consultation with the Councils on Legislation and Medical Services) be forwarded to NJHA indicating opposition to the NJHA position statement on Free-Standing Ambulatory Care Facilities.

Amendment of PSRO and Evaluation of New Jersey Foundation for Health Care Evaluation—Resolution #6 (1974 House of Delegates) . . . Received the following official list of suggested amendments to P.L. 92-603 from the AMA, in accordance with MSNJ's request as mandated in the second "resolved" of Resolution #6:

1. The definition of "qualified organization" under Section 1152 (b) (1) (A) should be expanded so that organizations, including foundations, designated by medical societies will be specifically eligible for consideration as a PSRO.

2. (A) Authority for the Secretary to enter into PSRO contracts with groups other than professional associations, as provided in Section 1152 (b) (1) (B), should be postponed from January 1, 1976, to July 1, 1978.

(B) The National Professional Standards Review Council should conduct a study to review the extent of professional participation in the implementation of the PSRO program. Such study would be completed by January 1, 1978, and thereupon presented to Congress, at which time Congress could determine whether, and under what conditions, other agencies would be allowed to serve as PSROs.

3. (A) Section 1156 should be amended to specifically direct the respective PSROs to ascertain and develop appropriate guidelines, (referring to norms, criteria and standards) drawing upon the expertise of national, state, and county medical associations and specialty societies.

(B) The law should be amended to specifically state that such guidelines (referring to norms, criteria and standards) are to be guides only and cannot be substituted for individual professional judgment.

4. Consistent with policy in opposition to preadmission certification of institutional care, such authority presently existing in the PSRO law should be deleted.

5. "Regular Review" of Patient and Provider profiles should not be required to be based upon case-by-case analysis of care provided or received. Section 1155 (a) (4) should be amended to allow for the review on a sample basis.

6. Section 1160 (a) (3) providing for financial penalties in lieu of termination or suspension should be repealed. A system of graduated sanctions, clearly stating the maximum applicable penalty (such as, a suspension up to 30 days for the first finding by the PSRO that the provider or practitioner has established a pattern of practice which is unacceptable) should be established.

7. Certain reporting provisions require PSROs to submit to the Statewide Council, for forwarding to the Secretary, all determinations made by the PSRO that a practitioner or a provider has violated any obligations relating to necessity, quality or situs of care furnished (Section 1157 and 1160 (b) (1)). These provisions should be amended to require the PSRO to report to the Statewide Council only when it determines that a pattern of practice requires such attention or that a provider or practitioner has grossly and flagrantly violated the obligations imposed under the Act. Such determinations should be made only after a conference with the provider or practitioner in an attempt to seek compliance, and a finding that he or it has shown an inability or lack of desire or intention to comply with the program requirements.

8. Section 1167 should be amended to provide that the written records of Professional Standards Review Organizations, Statewide Professional Standards Review Councils, and the National Professional Standards Review Council shall not be subject to subpoena or discovery proceedings in any civil action; nor shall the identity of any member, employee, or person providing information, counsel or services be subject to subpoena or discovery proceedings, nor shall the discussion or deliberations of any such organization, council member, employee, or person be subject to subpoena or discovery proceedings in any civil action.

9. Section 1167 (c) should be repealed. (Section 1167 purports (in subsection (c)), to limit the liability of an individual furnishing items or services when such individual has acted in compliance with the norms of care applied by a PSRO, provided that he exercised due care in his conduct. This provision could have the unintended and undesirable effect of pressuring practitioners to adhere to the norms. Moreover, the provision is at best meaningless because on its face it is applicable only when the practitioner has exercised due care—the very issue at the heart of the malpractice issues.

10. The law should be amended to state the limited functions of the "norms, criteria, and standards" developed thereunder and to define their applicability in civil cases.

11. Section 1168, referring to the reimbursement of PSRO expenses, should be amplified so that contract applications will have an accurate understanding as to which organizational expenses will be reimbursable.

12. The law should be amended to provide for the appeal of area designations.

13. The law should be amended to provide for PSRO review of care delivered through all federal medical programs such as the Veterans Administration and Public Health Service.

14. Section 1155 (b) (4) should be repealed. PSROs would be authorized under Section 1155 (b) (4) to inspect the facilities in which care is rendered or services are provided by practitioners or providers. Institutions are currently subject to inspection by the Joint Commission on Accreditation of Hospitals, and, moreover, facilities are generally subject to regulation under state and local law. It has been observed that the further requirements of onsite inspections by PSROs would be an unwarranted duplication.

15. Section 1155 (b) (3) should be repealed. Practitioners and providers are obligated to maintain supporting documentation substantiating the necessity and quality of care provided under Medicare and Medicaid. These record-keeping requirements (Section 1160 (a) (1) (C) are duplicated by an ambiguous authorization under Section 1155 (b) (3) allowing PSROs to "examine the pertinent records" of practitioners and providers. This authority is, at best, redundant and could be the subject of abuse. It should be observed that unrestrained examinations of medical records would jeopardize their confidentiality.

16. The role of the state medical society should be further augmented by authorizing the Secretary to enter into contracts with the state medical society, or its designated organization, to provide technical and administrative assistance to PSROs in the administration of the PSRO program. Under such contracts, the organization would be reimbursed directly by DHEW.

17. Section 213 of P.L. 92-603, which describes circumstances under which payment may be made under Medicare for certain otherwise noncovered items and services, and under which recovery can be made from providers and practitioners, should be repealed.

18. Provisions of Section 207 of P.L. 92-603, relating to utilization review procedures under Medicaid should be repealed.

19. Section 229 of P.L. 92-603, authorizing the creation of program review teams, should be repealed.

Blood Centers in New Jersey . . . Directed that the President appoint an *ad hoc* committee to formulate guidelines to be presented to the blood banks throughout New Jersey for the uniform procurement of blood.

Symposium on "Psychiatry for the Physician" . . . Approved a request from the Carrier Clinic Foundation to cosponsor their annual symposium on "Psychiatry for the Physician," the theme of which is "Body, Mind, and Alcohol: A Biosocial Enigma."

Proposed Rule on Establishment of Axial Tomography Service . . . Voted to support the Radiological Society of New Jersey in its efforts to have the proposed ruling of the Health Care Administration Board limiting axial tomography to a single installation in New Jersey until June 1, 1976, re-evaluated.

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Communicable Disease Control Program of the New Jersey State Department of Health during July 1974:

	1974 July	1973 July
Aseptic meningitis	14	1
Primary encephalitis	4	0
Hepatitis: Total	159	120
Infectious	70	71
Serum	33	40
Unspecified	56	9
Malaria: Total	2	2
Military	0	1
Civilian	2	1
Meningococcal meningitis (Civilian)	7	0
Mumps	23	61
German measles	8	44
Measles	114	51
Salmonella	46	83
Shigella	36	18

Immunization Action Month

Immunization Action Month is a national cooperative effort to locate and immunize persons susceptible to childhood diseases that can be prevented through immunization. Immunization levels among preschool age children have been decreasing at an alarming rate in the United States during the past few years. In 1973, national surveys indicated that approximately 5.8 million of the nearly 14 million 1 to 4-year-old children were unprotected against either polio, measles, rubella, diphtheria, pertussis, or tetanus. Because of concern about the declining immunization status of preschool children, a number of organizations have united together better to inform parents and physicians about this problem. The Center for Disease Control in Atlanta is the coordinating agency for this

year's campaign which will include as participating organizations:

American Medical Association
American Academy of Pediatrics
American Academy of Family Physicians
National Medical Association
Conference of City and County Health Officers
Association of State and Territorial Epidemiologists
American Nurses Association
National League for Nursing
American School Health Association

The New Jersey State Vaccination Assistance Program strongly supports this effort. In addition, New Jersey will expand the campaign to a year-long project. Major program activity during the year will include working with local health departments to expand and upgrade immunization services in their municipalities and working with day-care centers, and elementary and secondary schools to facilitate the immunization of susceptible children. All private and public health care systems will be encouraged to audit the records of any child in that system to find gaps in immunization history and provide protection where it is needed.

The cooperation, assistance, and participation of all health care personnel within the State is greatly needed so that the children of New Jersey are protected against these preventable diseases.

Therapeutic Drug Information Center

The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center, which is located at the Valley Hospital in Ridgewood, is a project of the New Jersey Regional Medical Program. The Center serves as a source of intelligence on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions, and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor of Pharmacy and Director of Drug Information, Brooklyn College of Pharmacy, is Project Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College is pharmacologist consultant. The service is free, available Monday through Friday from 9 a.m. to 5 p.m.—telephone (201) 445-4900, extension 132. Below are three questions and answers handled by the Center recently.

1. Is there a substitute product available for Alertonic® as it is no longer commercially available?

Alertonic® contained pipradrol hydrochloride in an aqueous vehicle and was recommended as a CNS stimulant. (At one time it was also recommended for poor appetite.) The total recommended daily dose of 45 ml contained 2.0 mg of pipradrol and was to be administered in 3 divided doses 30 minutes before meals. Pipradrol hydrochloride is still presently available in tablets containing either 1.0 mg or 2.5 mg (Meratran® —Wm. S. Merrell Co.).*

Recently the effectiveness of this amphetamine-like stimulant was tested in a double-blind study.[1] Pipradrol was administered to 111 mildly depressed outpatients in a dose of 5.0 to 7.5 mg per day. To be included in the study, it was necessary for patients to display a moderate degree of fatigue or lethargy and to be suffering from at least a mild degree of depressed mood. Only a few patient- but no physician-measures indicated any superiority of pipradrol over placebo. Pipradrol caused significantly more side effects and was associated with more anorexia and weight loss than placebo. Another controlled study by Brauzer and coworkers[2] found a few significant treatment differences in favor of pipradrol. However, differences were observed only in physician-executed ratings of depressed mood and sadness, and not in a patient-completed 35-item neurotic symptom checklist.

Present results thus suggest, at most, only limited efficacy of pipradrol in the treatment of depressed patients.

References

[1]Rickels K, *et al:* Pipradrol in mild depression: a controlled study. *J Clin Pharmacol* 14:127-133 (Feb-Mar) 1974.

[2]Brauzer B, *et al:* The re-evaluation of a central nervous stimulant: pipradrol hydrochloride. *Curr Therap Res* 14:780 (Dec) 1972.

2. Can 5-fluorouracil be given by mouth to treat cancer of the gastrointestinal tract?

The only commercially available form of 5-fluorouracil (5 F.U.) for internal use is the ampule intended for intravenous use only. However, although not approved

*We believe that this product will also be removed from the market due to present FDA regulations.

by the FDA, 5 F.U. has been used orally for many years. In 1966 Khung, *et al.*[1] reported on a trial of oral 5 F.U. in patients with metastatic cancer of the breast, stomach, colon, and rectum. The study concluded that the use of oral 5 F.U. in solution was a practical form of therapy, simple, effective, safe, and as well tolerated as when given by the intravenous route. The oral solution was prepared by adding the calculated intravenous dose (using the commercially available 500 mg per 10 ml ampule) to 50 ml of tap water.

In another study in which oral 5 F.U. was used, Lahiri, *et al.*[2] concluded that it was both safe and effective in treatment of metastatic colorectal carcinoma. Once again, the intravenous form was used, added to either water or fruit juice.

In a review article on the use of 5 F.U. for gastrointestinal neoplasia, Kaufman[3] stated that oral administration is safe, palatable when mixed with grapefruit juice or similar diluent, well tolerated, and effective. He concluded that oral and intravenous 5 F.U. seemed to have equivalent effectiveness and similar toxicity.

Bruckner, *et al.*[4] recently presented data on the urinary excretion and plasma concentration of 5 F.U. after intravenous and oral therapy. He reported that when 5 F.U. was administered by mouth the drug concentrations in both blood and urine were comparable to and more sustained than those achieved after intravenous injection in four of seven patients. This finding served as evidence that the same precautions against drug side effects should be taken with oral as with intravenous therapy. Further it showed that oral and intravenous administration could result in different blood levels of 5 F.U. (One patient who failed to respond to 5 F.U. intravenously responded to oral 5 F.U.)

In conclusion, administration of 5 F.U. orally has been shown to be effective in certain diseases. However, its use by this route is considered experimental.

References

[1]Kung C L, *et al:* A clinical trial of oral 5-fluorouracil. *Clin Pharmacol Ther* 7:527-533, 1966.

[2]Lahiri S R, *et al:* Treatment of metastatic colorectal carcinoma with 5-fluorouracil by mouth. *Cancer* 28:902-906 (Oct) 1971.

[3]Kaufman S: 5-fluorouracil in the treatment of gastrointestinal neoplasia. *N Engl J Med* 288:199-201 (Jan 25) 1973.

[4]Bruckner H W and Creasey W A: The administration of 5-fluorouracil by mouth. *Cancer* 33:14-18 (Jan) 1974.

3. Since different doses of protamine sulfate are required to neutralize heparin derived from intestinal mucosa than that derived from lung tissue, is there a therapeutic difference between the two types of heparins?

There is a difference in potency of heparin derived from various tissues on a milligram basis, but the therapeutic response is the same provided equal units (measurement of activity) are prescribed.[1] The United States Pharmacopoeia states that 1 mg of heparin sodium from lung tissue possesses an activity of not less than 120 USP units, while 1 mg of heparin sodium from other tissue (intestinal mucosa), a more potent heparin, has not less than 140 USP units of activity.[2] A prescribed dose of 100 mg of heparin would contain at least 12,000 units of heparin if derived from lung tissue and at least 14,000 units of heparin if derived from intestinal mucosa. However, a dose prescribed in units would provide the same degree of response regardless of the source of heparin. Thus the dosage of heparin should always be stated in units of activity rather than milligrams.

Protamine sulfate neutralizes heparin as an acid-base reaction, 1 mEq of each is required for neutralization, and reacts to a given weight of heparin rather than to an amount of activity.[3] Since the activities of the two types of heparin are different on a weight basis, 1 mg of protamine sulfate will neutralize 80 units of the less potent heparin derived from lung and 100 units of the more potent heparin derived from intestinal mucosa.

References

[1]Baltes B *et al:* Comparison of anticoagulant activity of two preparations of purified heparin. *Clin Pharmacol Ther* 14:287-290 (Mar-Apr) 1973.

[2]Anon: *The United States Pharmacopoeia,* 18th Revision. Mack Printing Company, Easton, Pennsylvania, 1970, p. 629-630.

[3]Prus R M: Letter to the editor. *JAMA* 228:569 (Apr 29) 1974.

4. Do you have any information concerning the possibility of amphetamines increasing the risk of cancer?

Two teams of scientists have warned that persons taking diet pills may be at increased risk of Hodgkin's disease. Preliminary data based on a study of 100 Hodgkin's disease patients and 100 matched controls indicated that patients with Hodgkin's disease were more than six times as likely to have taken amphetamines, usually for weight control, within two years of becoming ill.[1]

Berry[2] described a case of acute myeloblastic leukemia in a 24-year-old amphetamine addict. The addict had taken massive doses of this drug over more than two years. This report discussed the known hematological effects of amphetamine and speculated that the association might not be due to simple coincidence.

These preliminary findings must be repeated and confirmed by other researchers; meanwhile, the possibility of producing malignant lymphoma as well as the possibility of activating a dormant malignancy by amphetamines that stimulate lymphoid tissue must not be ignored.

References

[1]Anon: *Med World News* 15:15 (Feb 15) 1974.

[2]Berry J N: Acute myeloblastic leukemia in a benzedrine addiction. *South Med J* 59:1169-1170 (Oct) 1966.

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Folic Acid	0.1 mg.
Vitamin B-12	1.5 mcg.
Methionine	12 mg.
Choline Bitartrate	15 mg.
Inositol	10 mg.
Calcium Pantothenate	2.5 mg.
Pyridoxine	0.25 mg.
Copper (from Copper Sulfate)	0.25 mg.
Zinc (from Zinc Oxide)	0.25 mg.
Iodine (from Potassium Iodide)	0.075 mg.
Calcium (from Dicalcium Phosphate)	72.5 mg.
Phosphorus (from Dicalcium Phosphate)	55 mg.
Potassium (from Potassium Sulfate)	2.5 mg.
Manganese (from Manganese Sulfate)	0.5 mg.
Magnesium (from Magnesium Sulfate)	0.5 mg.

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CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

We are all well aware of the shortage of family physicians in New Jersey and throughout the country. It has many ramifications including dissatisfaction on the part of "consumers," and hard work—indeed, over-work—on the part of those who still bear the demands placed upon them. But the situation is changing, and in the public's mind, as well as among professionals, the label "family practice" is a prideful one.

We at CMDNJ are working hard to meet the shortage of generalists qualified and willing to do everything from delivering babies to treating an earache. This year the department of family medicine at the Rutgers Medical School in Piscataway began a new course for its senior students consisting of a four-week clerkship on a one-to-one basis with a practicing family physician. For obvious reasons of convenience, the program is concentrated in the Central Jersey area. During the four-week period, the student actively participates in the daily life of his doctor preceptor, sharing and observing his hospital rounds, home visits, office practice, and continued post-graduate training.

Most of the students serve as assistants to their mentors, working under supervision, of course, if the patient consents. They gain invaluable experience taking histories, doing physical examinations, and drawing conclusions. Then the general practitioner reviews the case and prescribes care accordingly.

Dr. Frank Snope, chairman of the RMS Department of Family Medicine, reports the students have proved themselves to be capable of working with minimal supervision. But it isn't easy for the preceptor, who holds the faculty rank of clinical instructor of family medicine. He does have to go over his student's work, in detail, and so may work even harder and longer than normally.

We have found there are many plus aspects to the program. For example, students become interested in the patients and can give them more time than the physician can by himself. The student can explain the medication and go over after-care instructions in detail. It is a learning experience in human communication, as well as in medicine. The clerkship exposes the students to an aspect of medicine that they might not usually practice. It has certainly attracted attention and interest among our students.

Last fall, one of our seniors planned to become an orthopedic surgeon. After clerkship with a general practitioner in Hunterdon County, he switched to family medicine. A June graduate of CMDNJ, he says that seeing his mentor working "in all sorts of situations, treating everything from high blood pressure to skin disorders," convinced him to become a family practitioner. He is continuing his training in family medicine as a resident at Overlook Hospital, in Summit.

Many of our students apparently were intrigued by their four-week look at the life of a family practitioner. Five of the 31 students in this year's graduating class at CMDNJ-Rutgers Medical School decided to pursue careers in family medicine. Since this is our first four-year class at RMS, we have no basis for comparison, but Dr. Snope says that when he was graduated from New York University's Medical School in 1958 there were none interested in that sequence. I believe our experience is representative of a national trend among students away from specialization.

CMDNJ is proud to be in the forefront of the movement. The family practice clerkship is proving an invaluable part of the training of today's medical student. It is a program that we hope will grow in the years ahead. It is but one of the exciting things that are happening at the College of Medicine and Dentistry of New Jersey.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

EMERGENCY ROOM—Jeffrey S. Menkes, M.D., 41 Morris Road, West Orange 07052. Yale 1972. Hospital or group. Available September 1974.

GENERAL PRACTICE—Young S. Kim, M.D., 420 Stockholm Street, Apt. B-10, Brooklyn, New York 11237. Yonsei (Korea) 1964. Board eligible in internal medicine. Solo partnership, or group. Available January 1975.

INTERNAL MEDICINE—Joseph G. Boak, M.D., 1455 Jericho Rd., Abington, Pennsylvania 19001. Univ. of Pennsylvania 1970. Board certified. Subspecialty cardiology. Group. Available.

Thomas J. Cuomo, Jr., M.D. 5405 Markview Lane, Richmond, Virginia 23234. Jefferson 1968. Board eligible. Subspecialty, cardiology. Group or partnership. Available June 1975.

Harry Seneca, M.D., 420 Park Place, Fort Lee 07024. Tulane 1943. Board certified, Subspecialty, gastroenterology, immunology. Group or partnership. Available.

Stephen Glouberman, M.D., 1403-A Washington Blvd., San Francisco 94129. SUNY (Downstate) 1966. Board eligible. Subspecialty, gastroenterology. Group or partnership. Available January 1975.

Manjit Singh, M.D., 1874 Pelham Parkway, South, Bronx, New York 10461. New Delhi 1966. Group or partnership. Available.

Syed A. Qaiyam Jafri, M.D., 390 1st Avenue, Apt. 11-H, New York 10010. Liaquat (Pakistan) 1965. Board certified. Subspecialty, cardiology. Group, solo, hospital, teaching. Available December 1974.

Vincent T. Randazzo, M.D., 3719 Sebille Drive, Alexandria, Louisiana 71301. Jefferson 1973. Board certified. Group, partnership, or hospital. Available August 1975.

Yen-Jen Fuh, M.D., University Hospital, University of Kentucky, Lexington, Kentucky 40506. National Taiwan University 1963. Board certified. Group or partnership. Available.

NEUROLOGY—Sang Jin Yoo, M.D., 4470 Granada Boulevard, Apt. 7, Warrensville Heights, Ohio 44128. Yonsei (Korea) 1969. Group or solo. Available January 1975.

OBSTETRICS AND GYNECOLOGY—Richard Fox, M.D., 200 Carman Ave., Apt. 19-B, East Meadow, New York 11554. St. Louis 1970. Association or partnership. Available July 1975.

Whan Soon Chung, M.D., 104 Sundridge Dr., North Tonawanda, New York 14120. Yonsei (Korea) 1966. Board eligible. Solo, group, partnership. Available January 1975.

Hugo Cimber, M.D., Tower Mountain Drive, Bernardsville 07924. Zurich (Switzerland) 1954. Board certified. Group, partnership, or hospital. Available.

Anant R. Bhati, M.D., 506 Dixmyth Avenue, Cincinnati, Ohio 45220. S.M.S. Medical College, Jaipur (India) 1964. Board eligible. Group, partnership, or solo. Available August 1974.

OTOLARYNGOLOGY—Nae H. Park, M.D., 515 West 59th Street, Apt. 5-N, New York 10019. Kyung Pook (Korea) 1966. Board eligible. Solo, partnership, group. Available July 1, 1975.

Nabeel M. El Romman, M.D., 921 St. Ann Place, Richmond, Virginia 23225. Cairo University 1968. Partnership or solo. Available July 1975.

PATHOLOGY—Satish C. Shah, M.D., 229-26 Kingsbury Avenue, Flushing, New York 11366. B.J. Medical (India) 1964. Board eligible. Solo, institution, group, or partnership. Available.

PEDIATRICS—Jerry J. Ferlauto, M.D., 2210 Auburn St., Rockford, Illinois 61103. Bologna (Italy) 1971. Board eligible. Subspecialty, neonatology. Group, partnership, or hospital. Available January 1975.

Barton W. Kaplan, M.D., 4358 Millwood Circle, Liverpool, New York 13088. SUNY (Upstate) 1968. Board eligible. Group or association. Available June 1975.

John A. Niziol. M.D., 5831 Walnut Street, Apt. 2, Pittsburgh 15232. Maryland 1972. Board eligible, Group or partnership. Available June 1975.

Joseph A. Hesch, M.D., Box 62, Avalon, New Jersey 08202. Jefferson 1934. Board certified. Part or full-time, salaried, clinical or executive. Available March 1975.

Arnold Kramer, M.D., 445 Edgemont Avenue, Palmerton, Pa. 18071. Duke 1962. Board certified. Association. Available.

SURGERY—Enrique A. Saenz, M.D., McDonald Army Hospital, Fort Eustis, Virginia 23604. Javeriana (Bogota, Colombia) 1962. Group or partnership. Available January 1975.

Wuk Kim. M.D., 900 Woodward Avenue, Pontiac, Michigan 48053. Pusan (Korea) 1966. Board eligible. Partnership (would include general practice). Available July 1975.

Peter Salzer, M.D., 200 Carman Avenue, Apt. 13-A, East Meadow, New York 11554. Tufts 1970. Group. Available July 1, 1975.

Emil Von Arx, M.D., 55 Culberson Road, Basking Ridge 07920. Boston University 1967. Board eligible. Group or partnership. Available.

UROLOGY— Harinath Kumar, M.D., 26 Meadow St., Demarest 07627. Gandhi (India) 1963. Group, partnership, or solo. Available.

Roger Wolfert, M.D., 101-B Birch Circle, Elgin AFB, Florida 325-42. SUNY (Downstate) 1968. Partnership or group. Available July 1975.

1974-1975
Committees and Councils

STANDING COMMITTEES

Annual Meeting

Arthur Bernstein, M.D., *Chairman* (1975) Maplewood
Francis X. Keeley, M.D., *Vice Chairman* (1977) Haddonfield
Nicholas A. Bertha, M.D. (1976) Wharton
Robert Brill, M.D. (1976) Passaic
James H. Spillane, M.D. (1977) Phillipsburg
Robert E. Verdon, M.D. (1975) Cliffside Park
Charles L. Cunniff, M.D., *Secretary* Ex-officio Jersey City

Scientific Exhibits

Francis X. Keeley, M.D., *Chairman* Haddonfield
Frank DeMaria, Jr., M.D. Hawthorne
H. Irving Dunn, M.D. Bay Head
George L. Erdman, M.D. Summit
Martin Rush, M.D. Red Bank

Scientific Program (Sections)

Allergy
Carl Dubovy, M.D., *Chairman* Boonton
Morton J. Seligman, M.D., *Secretary* Ridgewood

Anesthesiology
Robert K. Egge, M.D., *Chairman* Maplewood
Harold J. Cordner, Jr., M.D., *Secretary* Montvale

Cardiovascular Diseases
Harry A. Roselle, M.D., *Chairman* Englewood
Stelio Mangiola, M.D., *Secretary* Morristown

Chest Diseases
Norman Edelman, M.D., *Chairman* Piscataway
Theodore H. Weinstein, M.D., *Secretary* Flemington

Clinical Pathology
Paul T. Wertlake, M.D., *Chairman* Short Hills
Stephen V. D. Chandler, M.D., *Secretary* Somerville

Dermatology
Alfred J. Shapiro, M.D., *Chairman* Long Branch
Paul A. Possick, M.D., *Secretary* Westwood

Emergency Medicine
Rudolph E. Schwaeble, M.D., *Chairman* Mendham
James E. George, M.D., *Secretary* Woodbury

Family Practice
Ralph J. Fioretti, M.D. *Chairman* Rochelle Park
Seymour Taffet, M.D., *Secretary* Bloomfield

Gastroenterology and Proctology
Samuel B. Labow, M.D., *Chairman* Millburn
Klaus J. H. Meckeler, M.D., *Secretary* Somerville

Medicine
Paul K. Bornstein, M.D., *Chairman* Asbury Park
Frank J. Malta, M.D., *Secretary* Toms River

Neurosurgery and Neurology
Harold H. Goldberg, M.D., *Chairman* Hackensack
William Sagen, M.D., *Secretary* Trenton

Obstetrics and Gynecology
Michael R. DeVita, M.D., *Chairman* Westwood
Robert A. Haines, M.D., *Secretary* Camden

Ophthalmology
Carl J. Silodor, M.D., *Chairman* Wayne
Arnold B. Popkin, M.D., *Secretary* Hightstown

Orthopaedic Surgery
Kenneth A. Morrissey, M.D., *Chairman* Teaneck
Kenneth S. Klein, M.D., *Secretary* New Brunswick

Otolaryngology
David O. Zenker, M.D., *Chairman* Morristown
Mark Levey, M.D., *Secretary* Irvington

Pediatrics
Arthur Maron, M.D., *Chairman* West Orange
William C. Ellis, M.D., *Secretary* Long Branch

Physical Medicine and Rehabilitation
Norman H. Schachtel, M.D., *Chairman* Maplewood
Philip Brien, M.D., *Secretary* West Orange

Plastic and Reconstructive Surgery
Albert Davne, M.D., *Chairman* Trenton
John L. Krause, Jr., M.D., *Secretary* Cherry Hill

Psychiatry
Thomas R. Houseknecht, M.D., *Chairman* Moorestown
William H. Bristow, Jr., M.D., *Secretary* Ridgewood

Radiology
Fred M. Palace, M.D., *Chairman* Morristown
Daniel S. Cukier, M.D., *Secretary* Hackensack

Rheumatism
N. A. Cannarozzi, M.D., *Chairman* Montclair
William E. Ryan, M.D., *Secretary* Trenton

Surgery
Eric J. Lazaro, M.D., *Chairman* Jersey City
Louis M. DelGuercio, M.D., *Secretary* Livingston

Urology
Alfred R. Bozzo, M.D., *Chairman* Newton
Robert B. Ambrose, M.D., *Secretary* Morristown

Credentials

Charles L. Cunniff, M.D., *Chairman (Secretary)* Ex-Officio Jersey City
Elbert H. Pogue, M.D., *Vice-Chairman* (1977) Elizabeth
Frank J. T. Aitken, M.D. (1975) Bridgeton
Thaddeus Balinski, M.D. (1976) Perth Amboy
Charles E. Gilpatrick, M.D. (1975) Carney's Point
John W. Nicholson, III, M.D. (1976) Moorestown
Howard J. Rosenbauer, M.D. (1977) Hackensack

Finance and Budget

David Eckstein, M.D., *Chairman* (1975) Trenton
I. Edward Ornaf, M.D., *Vice-Chairman* (1976) Cherry Hill
Charles S. Krueger, M.D. (1977) Mount Holly
Barry M. Kotler, M.D. (1976) Piscataway
Louis G. McAfoos, Jr., M.D. (1975) Cherry Hill
James S. Todd, M.D. (1977) Ridgewood
Samuel J. Lloyd, M.D., *Treasurer,* Ex-Officio Trenton

Honorary Membership

Charles H. Calvin, M.D., *Chairman* (1975) Edison
Ralph M. L. Buchanan, M.D., *Vice-Chairman* (1976) Phillipsburg
William J. D'Elia, M.D. (1977) Spring Lake

Medical Defense and Insurance

Paul J. Kreutz, M.D., *Chairman* (1975) ..... Elizabeth
Alfred A. Alessi, M.D., *Vice-Chairman* (1975) Oradell
Irving P. Borsher, M.D. (1977) ..... Newark
Anthony P. DeSpirito, M.D. (1976) .... Neptune City
William G. Kuhn, Jr., M.D. (1976) .. New Brunswick
Frank J. Malta, M.D. (1977) ..... Toms River
Charles L. Cunniff, M.D., *Secretary* Ex-Officio ..... Jersey City
William J. D'Elia, M.D., *Consultant* .... Spring Lake
Ernest C. Hillman, Jr., M.D., *Consultant* .. Glen Ridge
Jesse Schulman, M.D., *Consultant* ..... Lakewood
Benjamin F. Slobodien, M.D., *Consultant* ..... Perth Amboy

Medical Education

Arthur Bernstein, M.D., *Chairman* (1977) Maplewood
Frank C. Snope, M.D., *Vice-Chairman* (1976) ..... Flemington
Alfred A. Alessi, M.D. (1977) ..... Oradell
Maurice J. Elovitz, M.D. (1976) ..... Atlantic City
Howard L. Nunes, M.D. (1975) ..... Jersey City
Edward H. Weiser, M.D. (1975) ..... Sussex
William F. Minogue, M.D., *Consultant* ..... Summit
William S. Vaun, M.D., *Consultant* ..... Long Branch

Medical Student Loan Fund

William Greifinger, M.D., *Chairman* (1975) Belleville
Charles H. Calvin, M.D., *Vice-Chairman* (1976) Edison
Charles Cunningham, M.D. (1976) ..... Vineland
Joseph R. Jehl, M.D. (1977) ..... Clifton
William R. Muir, M.D. (1977) ..... Mount Holly

Physicians' Relief Fund

Joseph J. Kline, M.D., *Chairman* (1977) .... Trenton
Frederick W. Durham, M.D., *Vice-Chairman* (1976) ..... Haddonfield
John J. Bedrick, M.D. (1977) ..... Bayonne
A. Guy Campo, M.D. (1976) ..... Westville
Frank Y. Watson, M.D. (1975) ..... Montclair

Publication

Daniel B. Roth, M.D., *Chairman* (1976) .... Teaneck
John F. Marshall, M.D., *Vice-Chairman* (1975) ..... Trenton
Julio delCastillo, M.D. (1977) ..... Trenton
John J. McGuire, M.D., *President-Elect*, Ex-Officio ..... South Orange
Charles L. Cunniff, M.D., *Secretary*, Ex-Officio ..... Jersey City
Arthur Krosnick, M.D., *Editor*, Ex-Officio ... Trenton

Revision of Constitution and Bylaws

Hillel M. Ben-Asher, M.D., *Chairman* (1975) ..... Morristown
Daniel J. O'Regan, M.D., *Vice-Chairman* (1976) ..... Jersey City
William A. Dwyer, Jr., M.D. (1976) ..... Paterson
Lawrence B. Owen, M.D. (1977) ..... Woodstown
Carl A. Restivo, M.D. (1975) ..... Jersey City
Arthur G. Sullivan, Jr., M.D. (1977) ... Bound Brook
Charles L. Cunniff, M.D., *Secretary*, Ex-Officio ..... Jersey City
Louis F. Albright, M.D., *Consultant* ..... Spring Lake

Woman's Auxiliary

William J. Roe, M.D., *Chairman* (1975) .. Englewood
Frederick W. Durham, M.D., *Vice-Chairman* (1977) ..... Haddonfield
Julius Baber, M.D. (1975) ..... Bayonne
James E. Brennan, M.D. (1976) ..... Cherry Hill
Dorothy Klughaupt, M.D. (1977) ..... Passaic
Alexander D. Kovacs, M.D. (1976) ..... Scotch Plains

ADMINISTRATIVE COUNCILS

Legislation

Meyer L. Abrams, M.D., *Chairman* (1977) Willingboro
John D. Franzoni, M.D., *Vice-Chairman* (1976) ..... Trenton
Donald P. Burt, M.D. (1975) ..... Morristown
John J. Crosby, Jr., M.D. (1976) ..... Jersey City
Leon A. Fraser, M.D. (1976) ..... Trenton
Winton H. Johnson, M.D. (1975) ..... Hackensack
John S. Madara, M.D. (1975) ..... Salem
Henry J. Mineur, M.D. (1975) ..... Cranford
Daniel J. O'Regan, M.D. (1977) ..... Jersey City
Francis A. Pflum, M.D. (1977) ..... Asbury Park
Ernest S. Redfield, M.D. (1976) ..... Woodbury
John R. Tobey, M.D. (1977) ..... Newark
David Eckstein, M.D., *Chairman, Board of Trustees*, Ex-Officio ..... Trenton
E. Powers Mincher, *Legislative Analyst* ... Pennington

Medical Services

R. E. Fullilove, Jr., M.D., *Chairman* (1976) .. Newark
R. H. Areson, M.D., *Vice-Chairman* (1975) Montclair
Victor H. Boogdanian, M.D. (1977) ... New Brunswick
Frank Campo, M.D. (1976) ..... Trenton
Arthur C. Dietrick, M.D. (1975) ..... Mount Holly
David Flinker, M.D. (1975) ..... Moorestown
Armando F. Goracci, M.D. (1975) ..... Woodbury
John H. Gould, M.D. (1977) ..... Shiloh
Joseph A. Lepree, M.D. (1977) ..... Elizabeth
James S. Todd, M.D. (1976) ..... Ridgewood
Charles O. Tyler, M.D. (1977) ..... Haddonfield
Sidney Woltz, M.D. (1976) ..... Union City
John J. McGuire, M.D., *President-Elect* Ex-Officio ..... South Orange
Matthew E. Boylan, M.D., *Consultant* .... Jersey City
A. Guy Campo, M.D., *Consultant* ..... Westville
Karl T. Franzoni, M.D., *Consultant* ..... Trenton
Frank M. Galioto, M.D., *Consultant* ..... Bloomfield
Nicholas E. Marchione, M.D., *Consultant* .... Vineland

Mental Health

Robert S. Garber, M.D., *Chairman* (1975) ..... Belle Mead
Edward A. Schauer, M.D., *Vice-Chairman* (1976) ..... Farmingdale
Harry H. Brunt, Jr., M.D. (1977) ..... Long Branch
Miles E. Drake, M.D. (1976) ..... Vineland
Evelyn P. Ivey, M.D. (1975) ..... Farmingdale
Clarence W. Jaggard, M.D. (1975) ..... Woodbury
Arnold Kallen, M.D. (1977) ..... Piscataway
Seymour F. Kuvin, M.D. (1976) ..... Livingston
J. Lloyd Morrow, M.D. (1977) ..... Passaic
Eugene V. Resnick, M.D. (1977) ..... Paramus
John R. Rushton, III, M.D. (1976) ..... Camden
Martin H. Weinberg, M.D. (1975) ..... Trenton
Matthew E. Boylan, M.D., *Immediate Past-President*, Ex-Officio ..... Jersey City

Public Health

Robert G. Salasin, M.D., *Chairman* (1975) ..... North Wildwood
Anthony P. DeSpirito, M.D., *Vice-Chairman* (1975) ..... Neptune City
Frank R. Begen, M.D. (1976) ..... Teaneck
William M. Chase, M.D. (1976) ..... East Orange
George L. Erdman, M.D. (1977) ..... Summit
Kendrick P. Lance, M.D. (1976) ..... Paterson
Thomas F. McLaughlin, M.D. (1976) ..... Metuchen
Watson E. Neiman, M.D. (1977) ..... Riverton
John J. Pastore, M.D. (1975) ..... Vineland
Francis E. Rieman, M.D. (1975) ..... North Bergen
Frederick C. Steller, M.D. (1977) ..... Spring Lake

Leslie B. Ultan, M.D. (1977) ..... Trenton
John S. Madara, M.D., *First Vice-President*
Ex-Officio ..... Salem
William J. Dougherty, M.D., *Consultant* .... Trenton
Martin Goldfield, M.D., *Consultant* ..... Trenton
Watson E. Neiman, M.D., *Consultant* ..... Trenton

Public Relations

Howard D. Slobodien, M.D., *Chairman*
(1976) ..... Perth Amboy
John P. Kengeter, M.D., *Vice-Chairman*
(1977) ..... Toms River
Frank R. Begen, M.D. (1975) ..... Teaneck
Robert Holman, M.D. (1975) ..... Pompton Plains
Andrew G. Hudacek, M.D. (1975) ..... Morristown
Francis X. Keeley, M.D. (1976) ..... Haddonfield
Frank J. Malta, M.D. (1977) ..... Toms River
John J. McGuire, M.D. (1976) ..... South Orange
Gastone A. Milano, M.D. (1975) ..... Atlantic City
John A. Sakson, M.D. (1977) ..... Yardley, Pa.
Ford C. Spangler, M.D. (1976) ..... Salem
Frank Y. Watson, M.D. (1977) ..... Montclair
Frank R. Begen, *2nd Vice-President,*
Ex-Officio ..... Teaneck

SPECIAL COMMITTEE TO THE COUNCIL ON MEDICAL SERVICES

Occupational Health, Workmen's Compensation, and Rehabilitation

Elmer J. Elias, M.D., *Chairman* ..... Trenton
Mathilda R. Vaschak, M.D.,
Vice-Chairman ..... North Plainfield
John W. Holdcraft, M.D. ..... Woodbury
Andrew G. Hudacek, M.D. ..... Morristown
Michael N. Jennings, M.D. ..... Matawan
Matthew M. Mishinski, M.D. ..... Camden
Daniel J. O'Regan, M.D. ..... Jersey City
William D. Van Riper, M.D. ..... Green Pond
Ralph A. Young, M.D. ..... Maplewood
Joshua N. Zimskind, M.D. ..... Trenton
Jarvis Smith, M.D., *Consultant* ..... Trenton

SPECIAL COMMITTEES TO THE COUNCIL ON MENTAL HEALTH

Alcoholism

Robert S. Albahary, M.D., *Chairman* .. New Brunswick
Robert E. Adams, M.D. ..... Morrisville, Pa.
David Canavan, M.D. ..... Oakland
Edwin D. Rogers, M.D. ..... Princeton
George A. Rogers, M.D. ..... Camden
Michael Shenkman, M.D. ..... Westwood
Robert F. Stuckey, M.D. ..... Metuchen

Drug Abuse

Laura E. Morrow, M.D., *Chairman* ..... Passaic
Mary Ann Bartusis, M.D. ..... Morrisville, Pa.
Granville L. Jones, M.D. ..... Summit
John W. Lathen, M.D. ..... Hackensack
Harry K. Panjwani, M.D. ..... Glen Rock
Francis E. Reiman, M.D. ..... North Bergen
Giesla Ucko, M.D. ..... Ridgewood
Edward A. Wolfson, M.D. ..... Glen Rock

Emotional Disorders of Childhood and Adolescence

Joseph J. Kline, M.D., *Chairman* ..... Trenton
Joseph C. Bogdan, M.D. ..... Neptune City
Jay W. Fidler, M.D. ..... Plainfield
Alan H. Kulick, M.D. ..... Vineland
Stanley D. Machlin, M.D. ..... Maywood
Alfonso J. Teresi, M.D. ..... Jersey City

Mental Retardation

Miles E. Drake, M.D., *Chairman* ..... Vineland
Theodore Kushnick, M.D. ..... Berkeley Heights
Gaetano Ruggieri, M.D. ..... Landing
Robert A. Weinstein, M.D. ..... Newton

Neurological and Related Disorders

J. Lloyd Morrow, M.D., *Chairman* ..... Passaic
George L. Becker, Jr., M.D. ..... Franklin Lakes
Michael Canelis, M.D. ..... Morristown
Josiah J. Pegues, M.D. ..... Mount Holly
Ira S. Ross, M.D. ..... South Orange
Walter Scheuerman, M.D. ..... Trenton

SPECIAL COMMITTEES TO THE COUNCIL ON PUBLIC HEALTH

Cancer Control

Roy T. Forsberg, M.D., *Chairman* ..... Westfield
Sherman Garrison, M.D. ..... Bridgeton
Warren H. Knauer, M.D. ..... Hillside
George P. Koeck, M.D. ..... Newark
Bernard J. Koven, M.D. ..... Englewood
Charles S. Krueger, M.D. ..... Mount Holly

Child Health

Glenn P. Lambert, M.D., *Chairman* .... Flemington
Marilyn L. Cannon, M.D. ..... Spring Lake
Carolyn M. DeMaria, M.D. ..... Hawthorne
William J. Farley, M.D. ..... Brielle
Douglas Ford, M.D. ..... East Orange
Robert E. Jennings, M.D. ..... South Orange
John J. LaMar, Jr., M.D. ..... Salem
Bernard N. Millner, M.D. ..... Trenton
Milton Prystowsky, M.D. ..... Nutley
Sidney Tucker, M.D. ..... Perth Amboy

Conservation of Vision, Hearing, and Speech

Alfonse A. Cinotti, M.D., *Chairman* ..... Jersey City
Bernard A. Balsis, M.D. ..... Trenton
Ralph L. Dicker, M.D. ..... Dover
Samuel Diskan, M.D. ..... Atlantic City
Joseph H. Kler, M.D. ..... New Brunswick
Oram R. Kline, M.D. ..... Camden
Rowan C. Pearce, Jr., M.D. ..... Haddonfield
Isadore M. Schnee, M.D. ..... Paterson
Ralph E. Siegel, M.D. ..... Perth Amboy
Ralph A. Skowron, M.D. ..... Cherry Hill
Aris M. Sophocles, M.D. ..... Trenton
Robert Stern, M.D. ..... Mount Holly
D. Blair Sulouff, M.D. ..... Morristown
Anthony M. Sellitto, M.D., *Consultant* .. South Orange
President and President-Elect, New Jersey Academy of Ophthalmology and Otolaryngology are also *Consultants.*

Environmental Health

Richard H. Musgnug, M.D., *Chairman* Medford Lakes
Seymour Charles, M.D. ..... Irvington
Wilbur J. Harley, M.D. ..... Westfield
E. Spencer Paisley, M.D. ..... Haddon Heights
Frank L. Rosen, M.D. ..... Maplewood
William I. Weiss, M.D. ..... Livingston
Meyer T. Weissman, M.D. ..... Elizabeth
Roslyn Barbash, M.D., *Consultant* ..... Teaneck
Morris Joselow, Ph.D., *Consultant* ..... Newark

Maternal and Infant Welfare

Edward Foord, M.D., *Chairman* ..... Burlington
Edward N. Comando, M.D. ..... Millburn
Robert A. Cosgrove, M.D. ..... Jersey City
Michael R. DeVita, M.D. ..... Westwood
Charles D. Foster, III, M.D. ..... Pitman
John D. Franzoni, M.D. ..... Trenton
Calvin Hahn, M.D. ..... Vineland
John D. Preece, M.D. ..... Trenton
Daniel B. Roth, M.D. ..... Teaneck
Harold Schwartz, M.D. ..... Millburn
Charles M. Scielzo, M.D. ..... Ridgewood
Jack E. Shangold, M.D. ..... Perth Amboy
William A. Kemick, M.D., *Consultant* ..... Trenton
Bernard N. Millner, M.D., *Consultant* ..... Trenton

SPECIAL COMMITTEES

Chronically Ill and Aging

(To be appointed)

Emergency Medical Care

Jack R. Karel, M.D., *Chairman* ..... Hillside
R. Winfield Betts, M.D., *Vice-Chairman* .... Medford
Clifford B. Blasi, M.D. ..... Jersey City
Charles P. Campbell, M.D. ..... Hackensack
William A. Dwyer, Jr., M.D. ..... Paterson
Dorson S. Mills, M.D. ..... Elmer
Daniel J. O'Regan, M.D. ..... Jersey City
Frank R. Schell, M.D. ..... Wayne
Rudolph E. Schwaeble, M.D. ..... Mendham
Michael D. Yablonski, M.D. ..... Hackensack
Marie A. Sena, M.D., *Consultant* ..... Toms River

Long Range Planning and Development

William J. D'Elia, M.D., (1976)
Chairman ..... Spring Lake
Alfred A. Alessi, M.D. (1976) ..... Hackensack
H. Oliver Brown, M.D. (1976) ..... Westfield
Leon C. Edwards, M.D. (1976) ..... Bedminster
Edward P. Healey, M.D. (1976) ..... Clifton
Mario E. Jascalevich, M.D. (1976) ... West New York
Philip J. LoPresti, M.D. (1976) ..... Haddon Heights
Kenneth Tuttle, M.D. (1976) ..... Flemington
Benjamin Wolfson, M.D. (1976) ..... Woodbury

Medicine and Religion

John J. Bedrick, M.D., *Chairman* ..... Bayonne
Reynold E. Burch, M.D. ..... Newark
Charles H. Calvin, M.D. ..... Edison
John S. Madara, M.D. ..... Salem
Thomas H. McGlade, M.D. ..... Camden
Watson E. Neiman, M.D. ..... Cinnaminson

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., *Chairman* .... Vineland
Albert F. Moriconi, M.D. ..... Trenton
Emanuel M. Satulsky, M.D. ..... Elizabeth

1974-1975 SPECIAL COMMITTEES SPECIAL LIAISON REPRESENTATIVES

Academy of Medicine of New Jersey

(1) Board of Trustees/Liaison Committee
(Liaison requested by Academy—6/19/66)
Edward G. Bourns, M.D. ..... Westfield
James A. Rogers, M.D. ..... Paterson
Howard D. Slobodien, M.D. ..... Perth Amboy

(2) Post-Graduate Medical Education Study Committe
(Representative requested by Academy—11/15/64)
Arthur Bernstein, M.D., *Chairman, Committee on Medical Education* .. Maplewood
Frank C. Snope, M.D., *Vice Chairman, Committee on Medical Education*. Flemington

Aging, Children, and Youth, Woman's Auxiliary Committee on

(Liaison requested by MSNJ's Woman's Auxiliary—11/19/72)
James A. Rogers, M.D. ..... Paterson

American Medical Association-Education Research Foundation

(Liaison requested by AMA-10/7/51)
William Greifinger, M.D., *Chairman, Committee on Medical Student Loan Fund* ..... Belleville

Audit Review Committee (1973-1974 Audit)

(Appointed annually by Board to review previous year's audit)
Louis F. Albright, M.D., *Chairman* ..... Spring Lake
Edward G. Bourns, M.D. ..... Westfield
Matthew E. Boylan, M.D. ..... Jersey City
Charles L. Cunniff, M.D. ..... Jersey City
William J. D'Elia, M.D. ..... Spring Lake
I. Edward Ornaf, M.D. ..... Camden
Consultants:
Samuel J. Lloyd, M.D., *Treasurer* ..... Trenton
David Eckstein, M.D., *Chairman, Committee on Finance and Budget* ..... Trenton

Bicentennial Celebration, Committee on National

(Established by Board of Trustees 7/19/70 to investigate the possibility of MSNJ's participation in the National Bicentennial Celebration in 1976)
Morris H. Saffron, M.D., *Chairman* ..... Passaic
David R. Brewer, Jr., M.D. ..... Woodbury
Peter J. Guthorn, M.D. ..... Neptune City
Fred B. Rogers, M.D. ..... Trenton

Blood Bank Association, New Jersey

(Liaison requested by New Jersey Blood Bank Association 4/25/69)
David Eckstein, M.D. ..... Trenton

Blue Cross-Blue Shield Plans of New Jersey, Permanent Committee on

(Appointment of committee requested by MSP—4/16/60)
David Eckstein, M.D., *Chairman, Board of Trustees* ..... Trenton
James A. Rogers, M.D., *President* ..... Paterson
Mr. Vincent A. Maressa, *Executive Director* .. Trenton
Equal representation from:
Medical-Surgical Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association

Board of Institutional Trustees, Department of Institutions and Agencies

(Appointed by Governor for 8-year term)
Frank J. Hughes, M.D. (1979) ..... Gloucester

Board of Nursing, New Jersey State

(Liaison requested by Board of Nursing—11/21/65)
Henry J. Mineur, M.D. ..... Cranford

Bureau of Investigation, Department of Law and Public Safety

(Cooperating committee requested by Department of Law and Public Safety—9/61)
Board of Trustees (Reaffirmed by Board of Trustees 5/14/74)

Cardiac Advisory Panel to Director of Motor Vehicles

(Panel requested by Special Commission on Traffic Safety—9/17/61—appointed by Director of Motor Vehicles)
Harry A. Kaplan, M.D. ..... Trenton
James G. Kehler, M.D. ..... Woodbury
John C. Wood, M.D. ..... Trenton

Community Medicine Advisory Council

(MSNJ representation requested by Richard J. Cross, M.D., CMDNJ at Rutgers—12/20/70)
Arthur Bernstein, M.D. ..... Maplewood
Victor H. Boogdanian, M.D. ..... New Brunswick

Comprehensive Health Planning Agency

(Liaison requested by the Comprehensive Health Planning Agency—12/16/69)
Nicholas E. Marchione, M.D., *State Health Planning Council* ..... Vineland
Irving P. Borsher, M.D., *Health Care Costs Committee* ..... Newark
Arthur Bernstein, M.D., *Medicaid Committee* ..... Maplewood
James A. Rogers, M.D., *Medical Education Facilities Committee* ..... Paterson

Crippled Children Commission, State

(Appointed by Governor for 5-year term)
Frederick G. Dilger, M.D. ..... Hackensack

Delaware Valley Regional Medical Program

(Established at invitation of University City Science Center—12/65)
Louis K. Collins, M.D. ..... Glassboro

Disputed Claims, Advisory Committee to Review MSP and HSP

(Established at request of MSP—8/21/60—Quorum: 4 members)
1st District—
Ralph M. Buchanan, M.D., *Chairman* ..... Phillipsburg
Charles I. Nadel, M.D. ..... Irvington
2nd District—
John J. Bedrick, M.D. ..... Bayonne
Robert A. Cosgrove, M.D. ..... Jersey City
3rd District—
John S. VanMater, M.D. ..... New Brunswick
John A. Kinczel, M.D. ..... Trenton
4th District—
John C. Clark, M.D. ..... Asbury Park
Frank J. Hughes, M.D. ..... Gloucester
5th District—
Don B. Weems, Jr., M.D. ..... Wenonah
Nicholas E. Marchione, M.D. ..... Vineland

Education, State Department of

(Liaison requested by the Assistant Commissioner of Education—9/21/58)
Glenn P. Lambert, M.D., *Chairman, Special Committee on Child Health* ..... Flemington

Board of Advisors to the Electrical Safety and Maintenance Program,

(MSNJ representation requested by New Jersey Hospital Association—12/1/72)
MSNJ's representative will work with the Association of Hospital Engineers to develop a safety code for New Jersey hospitals.
Bernard M. Schnur, M.D. ..... Trenton

Emotionally Disturbed Child, Advisory Council to Department of Education

(Liaison requested by Department of Education—10/28/68)
William J. Farley, M.D. ..... Brielle

Epilepsy, Advisory Panel to State Director of Motor Vehicles

(Established at request of Director of Motor Vehicles —7/29/66)
J. Berkeley Gordon, M.D. ..... Rumson

Executive Committee

(Provided in the Bylaws, Chapter VI, Section 5 (b))
James A. Rogers, M.D., *President (Chairman)* ..... Paterson
John J. McGuire, M.D., *President-Elect* ..... South Orange
John S. Madara, M.D., *First Vice-President* ..... Salem
Frank R. Begen, M.D., *Second Vice-President* ..... Teaneck
David Eckstein, M.D., *Chairman of the Board of Trustees* ..... Trenton

Health Careers Service, New Jersey

(Physician representation established by Board of Trustees 7/20/69)
Karl T. Franzoni, M.D. ..... Trenton

Health Careers Service, Resource Persons to New Jersey

(Liaison established at request of Health Careers Service—7/19/64)
Presidents of Component Societies

Health Insurance Conference

(Committee established at request of Health Insurance Council—3/24/57)
Charles L. Cunniff, M.D., *Secretary (Chairman)* ..... Jersey City
James A. Rogers, M.D., *President* ..... Paterson
John J. McGuire, M.D., *President-Elect* South Orange
John S. Madara, M.D., *First Vice-President* ..... Salem
Frank R. Begen, M.D., *Second Vice-President* ..... Teaneck
Mr. Vincent A. Maressa, *Executive Director* ..Trenton

Historian-Archivist

(Created at the suggestion of the Executive Director—1/13/57)
Morris H. Saffron, M.D. (Appointed 5/67) ...Passaic

Home Health Agencies, State Committee to Develop Standards for Licensure of

(MSNJ representation requested by the Secretary of the Licensure Committee of the New Jersey Department of Health—10/15/72)
David Eckstein, M.D. ..... Trenton

Hospital Association, New Jersey

(Liaison established at request of New Jersey Hospital Association—12/17/67)
John S. Madara, M.D. ..... Salem

Hospital Advisory Council, State Department of Institutions and Agencies

(Appointed by the Commissioner of Health for an indefinite term)

Nicholas E. Marchione, M.D. ..... Vineland

House Maintenance, Staff Policies, and Personnel Relations

(Special Committee created by Board of Trustees—9/21/58)

James A. Rogers, M.D., *President (Chairman)* ..... Paterson
John J. McGuire, M.D., *President-Elect* ..... South Orange
Charles L. Cunniff, M.D., *Secretary* ..... Jersey City
Samuel J. Lloyd, M.D., *Treasurer* ..... Trenton
David Eckstein, M.D., *Chairman, Board of Trustees and Chairman of the Committee on Finance and Budget* ..... Trenton
Mr. Vincent A. Maressa, *Executive Director* Trenton

HRET (Hospital Research and Educational Trust of New Jersey), Advisory Council to

(MSNJ representative requested by HRET. Appointment made by President 2/13/71. Council will assist HRET in processing data previously handled by State Health Facilities Planning Council.)

Mr. Vincent A. Maressa, *Executive Director* ..... Trenton

Industrial Safety Board, New Jersey

(Appointed by the Governor—8/71)

Delma W. Caldwell, M.D. ..... Linden

JEMPAC, Conference Committee with

(Established at request of JEMPAC—6/25/67)

Meyer L. Abrams, M.D. *Chairman, Council on Legislation* ..... Willingboro
Robert E. Fullilove, Jr., M.D., *Chairman Council on Medical Services* ..... Newark
Frank R. Begen, M.D., *Second Vice-President* ..... Teaneck

Judiciary and Bar, Conference Committee on Inter-Relations with the

(Established at invitation of Supreme Court—11/17/63)

A. Guy Campo, M.D. ..... Westville
Paul J. Kreutz, M.D. ..... Elizabeth
Samuel J. Lloyd, M.D. ..... Trenton
John S. Madara, M.D. ..... Salem
Nicholas E. Marchione, M.D. ..... Vineland
John J. McGuire, M.D. ..... South Orange
Emanuel M. Satulsky, M.D. ..... Elizabeth
James S. Todd, M.D. ..... Ridgewood
James A. Rogers, M.D., *President* ..... Paterson
Mr. Vincent A. Maressa, *Executive Director* ..... Trenton
Mr. Joseph C. Lucci, *Executive Assistant* ..... Trenton

Equal representation from:
Supreme Court Committee on Relations with the Medical Profession

Legislation

(1) Federal Keymen
(Mechanism established by MSNJ—4/4/54—to serve as official intermediaries between MSNJ and the Federal legislators)
15 Congressional District Keymen
1 Senatorial Keyman

(2) State Keymen
(Mechanism established by MSNJ—7/13/52)
Keymen in 15 Legislative Districts/21 Component Societies

Medicaid, Negotiating Committee For

(Established by Board of Trustees to work with the State Medicaid Commission—12/22/68)

James A. Rogers, M.D., *President* ..... Paterson
John J. McGuire, M.D., *President-Elect* ..... South Orange
Robert E. Fullilove, Jr., M.D., *Chairman, Council on Medical Services* ..... Newark

Medicaid Peer Review Committee

(Established by Board of Trustees 4/19/70 at the request of the Department of Institutions and Agencies. The function of the Committee will be to act upon inquiries and/or complaints originating either with the administrators of the Medicaid Program or with physicians serving under the program.)

1st District—
Nicholas A. Bertha, M.D. ..... Wharton
2nd District—
Ambrose P. Boyle, Jr., M.D. ..... Fort Lee
3rd District—
David Eckstein, M.D. ..... Trenton
4th District—
Emanuel Abraham, M.D. ..... Asbury Park
5th District—
(Vacancy)

Medicaid Program, Medical Advisory Committee to the

(Appointment of four representatives requested by Department of Institutions and Agencies—6/12/69)

Donald P. Burt, M.D. ..... Morristown
Arthur C. Dietrick, M.D. ..... Mount Holly
John D. Franzoni, M.D. ..... Trenton
Leo J. Kelly, Jr., M.D. ..... South Orange

Medical Assistance Advisory Council

(Established at invitation of State Medicaid Commission—Board action 4/20/69)

A. Guy Campo, M.D. ..... Westville
Anthony P. DeSpirito, M.D. ..... Asbury Park

Medical Assistants, (State of New Jersey) American Association of

(Liaison established by MSNJ—9/15/63)

William J. D'Elia, M.D. ..... Spring Lake

Medical Education of New Jersey, Office of Continuing

(Liaison requested by College of Medicine and Dentistry of New Jersey—4/20/72)

John F. Kustrup, M.D. ..... Trenton
Arthur Bernstein, M.D. (alternate) ..... Maplewood

Medical-Hospital-Nursing Conference (Tri-Partite)

(Liaison established by MSNJ—1/13/57)

James A. Rogers, M.D., *President* ..... Paterson
John J. McGuire, M.D., *President-Elect* ..... South Orange
Matthew E. Boylan, M.D., *Immediate Past-President* ..... Jersey City
Mr. Vincent A. Maressa, *Executive Director* ..... Trenton

Equal representation from:
New Jersey Hospital Association
New Jersey State Nurses' Association

Medical Liaison Committees

(High-level conference groups for discussion and consideration of items of mutual interest)

James A. Rogers, M.D., *President* ..... Paterson
John J. McGuire, M.D., *President-Elect* ..... South Orange
Matthew E. Boylan, M.D., *Immediate Past-President* ..... Jersey City
Mr. Vincent A.Maressa, *Executive Director* ..... Trenton

(Where number of representatives from other organization is larger than number of MSNJ representatives, the latter will be increased from the Presidential Officers to equal the former.)

(1) Medical-Dental
(Liaison requested by the Dental Society—6/10/51)

(2) Medical-Hospital
(Liaison established by MSNJ—10/25/53)

(3) Medical-Legal
(Liaison established by MSNJ—10/25/53)
(4) Medical-Nursing
(Liaison established by MSNJ—4/4/54)
(5) Medical-Osteopathic
(Liaison requested by Osteopathic Association—9/17/61)
(6) Medical-Pharmaceutical
(Liaison established by MSNJ—7/26/53)

Medical School in South Jersey, Committee to Assist in the Implementation of Legislation to Establish a

(Established by Board—5/17/67)—Appointments by President)
Louis K. Collins, M.D., *Chairman* ..... Glassboro
A. Guy Campo, M.D. ..... Westville
Sherman Garrison, M.D. ..... Bridgeton
Frank J. Hughes, M.D. ..... Gloucester
John F. Kustrup, M.D. ..... Trenton
Fred A. Mettler, M.D. ..... Blairstown
James A. Rogers, M.D. ..... Paterson

Medical-Surgical Plan Board of Trustees

(Provided in MSP Bylaws)
James A. Rogers, M.D., *President* ..... Paterson

Medicare Peer Review Committee

(Established by Board of Trustees 12/20/70 at request of fiscal intermediary. Committee will review and evaluate claims involving questions of overutilization under Medicare. Composition of committee includes six groups of three members each in the fields of general practice, general surgery, orthopedic surgery, internal medicine, ophthalmology, and urology.)

Membership Directory

(Special committee established by Board—11/19/61)
Charles L. Cunniff, M.D., *Chairman* ..... Jersey City
Matthew E. Boylan, M.D. ..... Jersey City
William Greifinger, M.D. ..... Belleville
Daniel B. Roth, M.D. ..... Teaneck
Mr. Vincent A. Maressa, *Executive Director* ..... Trenton
Mr. Robert H. Lambert, *Bs. and Fin. Mgr.* ..... Trenton

Membership Inquiry and Complaint Mechanism

(Established at the 12/10/72 Special Session of the House of Delegates to deal more effectively with third party insurance carriers and government medical programs as they affect the practices of the membership.)

Membership Inquiry and Complaint Committee with Medical-Surgical Plan of New Jersey

Samuel Baum, M.D. ..... Passaic
Donald P. Burt, M.D. ..... Morristown
Arthur C. Dietrick, M.D. ..... Mount Holly
Karl T. Franzoni, M.D. ..... Trenton
James E. George, M.D. ..... Westville

Membership Inquiry and Complaint Committee with Medicare

Alfred A. Alessi, M.D. ..... Oradell
William H. Coleman, M.D. ..... Trenton
Richard H. DuPree, M.D. ..... Woodbury
Andrew G. Hudacek, M.D. ..... Morristown
Joseph W. Schauer, Jr., M.D. ..... Farmingdale

Membership Inquiry and Complaint Committee with Medicaid

John J. Crosby, Jr., M.D. ..... Jersey City
Michael J. Doyle, M.D. ..... Neptune
Armando F. Goracci, M.D. ..... Woodbury
Frederick J. Knocke, M.D. ..... Readington
Robert E. McNamara, M.D. ..... Newark

Membership Inquiry and Complaint Committee with Other Health Insurance Carriers

Melvin J. Andrews, M.D. ..... Cherry Hill
Emanuel M. Satulsky, M.D. ..... Elizabeth
Howard D. Slobodien, M.D. ..... Perth Amboy
Robert A. Weinstein, M.D. ..... Newton

New Jersey College of Medicine and Dentistry, Student AMA

(Liaison requested by New Jersey Chapter—1/26/60)
Edward A. Wolfson, M.D. ..... Glen Rock

Nurse Pediatrician or Pediatric Nurse, Advisory Council on the

(Liaison established by the Board of Trustees—2/27/72—at the request of Rutgers University)
Harold L. Colburn, Jr., M.D. ..... Moorestown

Nurses' Association, Joint Practice Committee with the New Jersey State

(Established by Board of Trustees—7/16/72—to clarify roles and functions of nursing and medicine within the health care delivery context, with the objective being the improvement of health care delivery services.)
William J. D'Elia, M.D., *Chairman* ..... Spring Lake
Matthew E. Boylan, M.D. ..... Jersey City
David Eckstein, M.D. ..... Trenton
Henry J. Mineur, M.D. ..... Cranford
James A. Rogers, M.D. ..... Paterson
Mr. Vincent A. Maressa, *Exec. Director* ..... Trenton

Nursing Facilities, Advisory Committee on Skilled

(MSNJ representation requested by Assistant Commissioner for Health Facilities, New Jersey Department of Health—4/30/73. The Committee will revise standards for licensure of skilled nursing facilities.)
David Eckstein, M.D. ..... Trenton

Nutrition Council, New Jersey

(Liaison established by MSNJ—12/19/54)
Harvey P. Einhorn, M.D. ..... South Orange

Ochampus (Office for Civilian Health and Medical Program of the Uniformed Services)

(1) Fiscal Agent
(Designated upon request of MSP—7/21/63)
Medical-Surgical Plan of New Jersey
(2) Special Committee on
(Established by MSNJ—9/9/56)
David Eckstein, M.D., *Chairman* ..... Trenton
George L. Benz, M.D. ..... Newark
I. Edward Ornaf, M.D. ..... Cherry Hill

Parents and Teachers, New Jersey Congress of

(Liaison requested by MSNJ's Committee on Child Health—12/20/64)
William J. Farley, M.D. ..... Brielle

Pension Plan, Special Committee on

(Established by Board—5/22/55 ..... Duties outlined in Article III of Pension Plan Agreement)
David Eckstein, M.D., (Chairman) *Chairman of Committee on Finance and Budget* ..... Trenton
James A. Rogers, M.D., *Chairman, Special Committee on House Maintenance, Staff Policies, and Personnel Relations* ..... Paterson
Samuel J. Lloyd, M.D., *Treasurer* ..... Trenton

Quackery, Committee on

(Established at the request of the AMA—11/15/64)
James S. Todd, M.D. *Chairman* ..... Ridgewood
Richard B. Berlin, M.D. ..... Englewood
Charles B. Norton, M.D. ..... Woodstown

Radiation Protection Commission, Consultant to New Jersey

(Nomination for appointment to Commission requested —7/18/65)

Bernard M. Schnur, M.D. ..... Trenton

Radiation Protection Commission, New Jersey

(Two consultants in nuclear medicine requested by the Commission 11/66)

Frank R. Schell, M.D. ..... Wayne

John J. Thompson, M.D. ..... Caldwell

Regional Planning Council, Philadelphia Medical Library Committee

(Appointment of representative requested by Library Committee—8/20/67)

Sherman Garrison, M.D. ..... Bridgeton

Rehabilitation Services, Division of Vocational

(Liaison requested by MSNJ's Committee on Rehabilitation—5/65)

Jarvis M. Smith M.D. ..... Trenton

Resolutions, Committee on Annual Meeting

(Established, by Board of Trustees—7/18/71—to review all resolutions in advance of the annual meeting)

Matthew E. Boylan, M.D., *Chairman* ..... Jersey City

William J. D'Elia, M.D. ..... Spring Lake

Emanuel M. Satulsky, M.D. ..... Elizabeth

Safety Council, New Jersey State

(Provided in Council Bylaws)

James A. Rogers, M.D., *President* ..... Paterson

Delma W. Caldwell, M.D., *President's Representative* ..... Linden

Selective Service System, New Jersey Chairman of Advisory Committee to

(Nomination for appointment by National Advisory Committee requested by committee—11/19/61)

Charles L. Cunniff, M.D. ..... Jersey City

Welfare Council, New Jersey

(Representative to plan meetings for annual conference on social welfare requested by Council—5/13/66)

John J. Bedrick, M.D. ..... Bayonne

Widows and Orphans of Medical Men of New Jersey, Society for Relief of

(Liaison requested by Society—5/17/59)

Joseph R. Jehl M.D. ..... Clifton

Armed Forces Medical Museum

The Armed Forces Medical Museum was opened to the public in 1862 and was originally housed in Ford's Theater, which had been converted into an office building following President Lincoln's assassination. It is now located on the grounds of Walter Reed Army Medical Center, Washington, D.C., in a modern, attractive complex. The Museum welcomes physicians, students, and health professionals, as well as the general public.

The Medical Museum has four exhibit sections, a theater, and a spacious reception lobby. The Hall of Pathology displays pathological specimens mounted in clear plastic containers, and arranged by organ systems. The Hall of History features the history of pathology, the role of the Armed Forces Institute of Pathology, and exhibits which trace the accomplishments of military pathologists from the Civil War to Vietnam.

The Hall of Instruments contains the most comprehensive collection of microscopes in the world, spanning the period from ca 1590 to a prototype model of the scanning electron microscope of the future. This hall also displays medical, dental and veterinary instruments, as well as exhibits dealing with trephination and biopsy techniques. The Hall of Current Events features a multimedia collection of timely exhibits about such topical subjects as drug abuse, automobile accidents, air pollution, and so on. The viewer is actively involved through films, slides, earphones, telephones, and other communication aids.

Russell Auditorium, a new theater, is used for private meetings, public lectures, student and visitor briefing and orientation, audio-visual presentations, and special events. Medical students are encouraged to review and utilize the Otis Historical Archives which contain early editions of pathology books, monographs, and original articles, as well as a unique collection of original letters and papers from the Civil War era.

The Curator of the Medical Museum is an Army Veterinarian, Colonel Joshua E. Henderson. Armed Forces Medical Museum, which is open seven days a week from 9 A.M. to 5 P.M., is located at 6825—16th Street, N.W., Washington, D.C.

CLINICAL NOTES

Extrarespiratory Cough Due To Infected Retroauricular Cyst

Elmar G. Lutz, M.D./Wayne

The cause of a cough is usually an upper respiratory infection but, perhaps not rarely, it may be extrarespiratory.

A chronic cough of three months' duration associated with hoarseness occurred in a five-year-old boy. The cough was frequent, periodic, spasmodic, diurnal, and nocturnal. It was not until after the incision, curettage and drainage of an infected dermoid cyst that the cough subsided and we found its explanation retrospectively.

This cyst was walnut-sized, located in the left retroauricular area overlaying the mastoid process and protruding somewhat into the posterior wall of the outer part of the external auditory meatus. Subacute in its development, the cyst produced marked local and regional pain, and neuralgia of the auricular branch of the vagus nerve which emerges into the cutaneous area posterior to the ear.

Mechanical stimulation (e.g., introduction of an ear speculum) of the external auditory canal in certain persons can produce cough. Such a stimulus affects Arnold's nerve, the auricular branch of the vagus nerve. While about one in 600 to 800 persons show this auricular nerve reflex, not all experience spontaneous cough. It is thought that packed cerumen, a foreign body, eczema, or other sources of irritation are necessary to produce the cough.

It is interesting that this patient did not have an auricular nerve reflex. The cough subsided following surgical treatment of the infected cyst and removal of impacted cerumen from the left ear.

Acupuncture and Sensori-Neural Hearing Loss

William Aber, Montclair*

Acupuncture is an ancient treatment method which has been used in China for thousands of years. Recently, since a number of physicians from the United States visited China, there has been developed an interest in this type of treatment in our country. There does not appear to be any known scientific basis for the practice of acupuncture, which according to legend, was developed over three thousand years ago by Emperor Shih Huang-Ti when he noted that wounds received in battle sometimes relieved ailments in other parts of the body. According to acupuncture practitioners, any disease that is caused by, or causes a physiological malfunction of the body, can be corrected by this technique. Chinese doctors worked out an elaborate theory of the flow of vital energy along twelve invisible pathways of the body called meridians and claimed that imbalance in the flow caused disease. Needles inserted at points along the meridians should change the flow and restore balance and health.

It is estimated that fifteen to twenty million people in the United States have some form of hearing loss, mainly inner-ear or nerve-type hearing loss. This type of loss, for the most part, is believed to be irreversible. Recent press notices have extolled the virtues of acupuncture for the restoration of hearing, causing audiologists and otolaryngologists to

*Mr. Aber is Chief Audiologist and Supervisor of the Audiology and Speech Pathology Department, Mountainside Hospital, Montclair

be deluged with phone calls and letters from patients requesting information.

To evaluate the claim, a study of thirty patients, age 4 to 60, with sensori-neural or nerve-type hearing loss, was planned. These patients, who had acupuncture treatments in Washington, D.C., New York, and New Jersey had hearing loss due to congenital deafness, acoustic trauma, presbycusis, mumps, and unknown causes.

Careful, comprehensive audiological testing was performed by a certified, experienced audiologist prior to acupuncture treatments and repeated one month after the treatments. These tests were conducted in sound-treated chambers with sophisticated audiological instrumentation calibrated well within the national standards. A Grason-Stadler 1701 audiometer was used to administer air conduction and bone conduction tests at frequencies of 125, 250, 500, 1000, 2000, 3000, 6000 and 8000 Hz. Speech reception and speech discrimination tests were also administered. The test results in all of the thirty patients indicated there was no significant improvement in hearing or in the ability to discriminate sounds following acupuncture treatments.

Acupuncturists are alleging improvement in hearing following their treatments. However, this study failed to provide evidence to support their claims. Based on the results following comprehensive audiological testing, I have great suspicion as to the worthiness of acupuncture in the area of hearing at this time.

LETTER TO THE JOURNAL

Postmortem on PSRO Position

June 23, 1974

Dear Sir:

The overwhelming issue at this year's convention was New Jersey's posture regarding PSROs and related matters. As indicated by the prevailing voting, I realize I speak for the minority present, however not necessarily for the minority of New Jersey physicians. Be that as it may, I feel my viewpoint is just and correct.

I was dismayed, disappointed and somehow felt embarrassed at the posture adopted by the House regarding our projected attitudes in these matters. Much of the debate was fuzzy-headed; many of the statements were based on half truths, outright incorrect facts and it seemed, even fear.

The conclusion reached supported a defeatist, better-red-than-dead philosophy.

If the delegates who supported this conciliatory approach—a rejection of "PSRO Repeal" in favor of a meaningless "PSRO Amendment"—truthfully believe that PSROs somehow are desirable, all well and good.

But the merits of these contrivances were not voiced. For the most part the proponents adopted an attitude that, all-is-lost, let's-join-them, let's accept-their-financial-hand-outs-and-hope-to-have-a-say-in-their-management attitude. HOG WASH! He who controls the purse strings controls all. If you don't buy this, just refer to today's arbitrary handling of the Medicare/Medicaid Programs.

In every hard-core national health insurance program now before Congress, it is conceded that success depends on viable PSROs. Gentlemen, if you genuinely believe that there is a major health-care crisis across the United States—a crisis which needs big brother, national bureaucratic aid to save the situation—so be it.

But if you believe our medical profession is and can do the job without outside meddling, if you believe no interphase should be placed between patient and physician, if you believe history has shown government's intervention in various modalities of American Life is usually disastrous—then stand up and fight. It may be a tough up-hill battle but with a united medical community and a singleness of purpose, this struggle *can* be won.

A delegate asked "how can we obtain repeal of PSRO?"

With all the confusion then at hand—no small amount contributed by the speaker's platform—no answer was forthcoming.

The first step is for each and every doctor to get the facts regarding the PSRO Law—then speak out—teach. Educate our law makers about the law's shortcomings.

I have personally had the privilege of visiting Washington and Congress over the past two years, and discussed PSROs with several law makers. It was surprising how few originally had any idea of the PSRO section—that is section 249F of the 1972 Social Security Act. Today things are different—103 congressmen are on record for repealing PSROs and there are 45 bills before Congress supporting repeal.

There are 18 state medical societies urging repeal and there are several state legislatures who have passed resolutions requesting congress to repeal PSRO.

In Atlantic County, partly because of our attempts at teaching, not only are the majority of physicians unalterably opposed to the PSRO concept but a good segment of our patients, and let's face it, our patients are pre-eminent, are opposed to federal, big brother intrusion into the private practice of medicine.

I am happy to say a repeal posture has been taken by our men in Washington, Congressman Charles Sandman and Congressman John Hunt.

Much of our support has come from people outside of medicine. Well informed viewpoints, objecting to government intervention are appearing regularly in magazines, on the radio and in the newspapers across the country.

A case in point is an editorial entitled "Smoke Screen Hazard To Health" which appeared recently in the St. Louis Globe Democrat.

For those of you who have similar feelings and, since The Medical Society of New Jersey does not presently care to carry the banner high as many of our sister-state societies have opted to do, there are rallying forces available to us—in particular the American Council of Medical Staffs and the American Association of Physicians and Surgeons.

To repeat, what is needed is to get the word out, to get the truth out. It would be far wiser to assess every Medical Society doctor, not to support the New Jersey Foundation but to buy media advertising space to apprise the public what the government is contemplating.

We hear in our scientific sessions of great advances in heart and renal transplants. I wish someone would perfect a backbone transplant. It might help several of our colleagues to *stand up* and *totally* resist the threatening federally imposed coup de grace to the long established private practice of medicine in our country.

PSRO can be repealed—will be repealed—must be repealed—for our patient's sake and for the freedom of private practice.

signed (Paul H. Steel, M.D.)

ANNOUNCEMENTS

Current Topics in Psychiatry

The Fair Oaks Hospital in Summit announces the first of its programs in the 1974-1975 series on current topics in psychiatry. Dates and topics of subsequent sessions will be announced in future issues of the Journal.

Sept. 11—Psychiatric Aspects of Child Abuse

Sessions are held from 3 to 4:30 p.m. in the Conference Room at the Hospital (19 Prospect Street). Granville L. Jones, M.D., Director of Research and Education at Fair Oaks, will be moderator and further information is available by writing directly to him.

The programs are cosponsored by the Academy of Medicine and are accredited for the AMA Physician's Recognition Award.

Pulmonary Disease Lectures

The Veterans Administration Hospital in East Orange and the New Jersey Medical School, CMDNJ are cosponsors of a 1974-1975 series of lectures in pulmonary diseases, to be held on Wednesdays at 11:30 a.m. at the Veterans Administration Hospital, East Orange, on the dates indicated.

September 18	Patient with Diminished Resistance to Pulmonary Infection
October 16	Aspiration Pneumonia and Lung Abscess
November 20	Histoplasmosis
December 18	Emergency Pulmonary Care
January 15	Rifampin, Tuberculin
February 19	Chemical Control of Respiration
March 19	Cor Pulmonale
April 16	Infectiousness of Tuberculosis before and after Chemotherapy
May 14	Respiratory Failure

Review Course in Internal Medicine

The Academy of Medicine and the New Jersey Medical School, CMDNJ, are the cosponsors of a five-day review course of recent advances in internal medicine. The dates are September 30 to October 4 and the place is the Coachman Inn in Cranford (exit 136, Garden State Parkway). Topics to be covered include infectious diseases, cardiology, endocrinology and metabolism, hematology, pulmonary diseases, oncology and immunology, liver diseases, gastroenterology, neurology, and rheumatology. The programs are under the cochairmenship of Drs. Francis P. Chinard and Murray Nussbaum. Tuition, which includes luncheon each day and dinner on October 3, is $200. Checks should be made payable to the Academy of Medicine. Registration is limited. For further information, please write to the Academy at 2424 Morris Avenue, Union, New Jersey 07083, or call (201) 687-8780.

Pediatrics Lecture

On October 11 from 9 a.m. to 12 noon, at the Overlook Hospital in Summit, a program on recent advances in pediatrics will be held under the sponsorship of the Departments of Pediatrics and Family Practice of that hospital. Speaker for the occasion is Sydney S. Gellis, M.D., Professor and Chairman of Pediatrics at Tufts University School of Medicine. The American Academy of Family Practice will award 3 credits for attendance and approval has also been granted for Category I, AMA Physician's Recognition Award.

Medical Women's Association Seminar

From October 25 to 28 the New Jersey Medical Women's Association will sponsor a seminar at the Concord Hotel, Kiamesha Lake, New York. Theme for this week-end meeting is "Money Management for the Woman Professional." For information concerning reservations and program details, please write to Mrs. Sande Rubin, Convention Coordinator, 63 Leland Avenue, Plainfield, New Jersey 07062.

Retraining Program for Physicians

A six-weeks retraining program for inactive physicians who wish to re-enter clinical medicine is offered by the Medical College of Pennsylvania from October 28 to December 6, 1974. The course includes lectures, seminars, group discussions, and patient work-ups in a review of diagnostic skills, general medicine, pathophysiology, and treatment management. The course is held at the College, 3300 Henry Avenue, Philadelphia 19129, telephone (215) 842-7108. There is no fee. Further information is available from Nina B. Woodside, M.D. at the College.

Training Program for Emergency Department Physicians

In cooperation with the Inter-Agency Commission on Emergency Medical Care, MSNJ will sponsor a training program for emergency department and other interested physicians in each of the Society's Judicial Districts from 9 a.m. to 4 p.m. on three successive Wednesdays, as indicated. (A similar course has been arranged for nurses at Morristown Memorial, Dover General, Princeton, Jersey Shore (Neptune), and Burlington County Hospitals.)

The series consists of lectures and demonstrations and the subjects included cover resuscitation of the severely injured patient, burns, emergencies of the chest and abdomen, musculoskeletal injuries, the unconscious patient, and psychiatric emergencies.

1st District	November 20 December 4 December 11	St. Elizabeth Hospital Elizabeth
2nd District	December 11 December 18 January 8	St. Joseph's Medical Center Paterson
3rd District	January 29 February 5 February 12	St. Francis Hospital Trenton
4th District	January 8 January 15 January 22	Monmouth Medical Center Long Branch
5th District	November 20 December 4 December 11	The Cooper Hospital Camden

Each course is limited to 100 persons and registration is required.

Applications will be mailed to every physician this month. The programs have been approved for Category I, AMA Physician's Recognition Award. For further information, please communicate with Jack R. Karel, M.D., Chairman, Inter-Agency Commission on Emergency Medical Care, 115 North Avenue, Hillside, New Jersey 07205.

Pediatric Continuing Education Courses in Florida

The Department of Pediatrics of the University of Miami School of Medicine has announced the following continuing medical education courses to be held in Bal Harbour, Florida this winter:

January 2 to 7—*Dynamics of Progressive Nephropathies, Theoretical and Practical Aspects.* Fee: $175 for practicing physicians; $75 for interns or residents; $100 for nurses.

January 29 to 31—*Human Diseases Related to Food and Chemical Sensitivity.* Fee: $175 for practicing physicians; $75 for interns or residents: $100 for nurses.

March 11 to 14—*Hypertension, Diabetes and Hyperlipidemia in Childhood and Vascular Disease in the Adult.* Fee: $175 for practicing physicians; $30 for interns or residents; $50 for nurses.

For information, please write to the Division of Continuing Medical Education, University of Miami School of Medicine, P.O. Box 520875 Biscayne Annex, Miami, Florida 33152.

New Jersey Diabetes Association

The New Jersey Diabetes Association formally affiliated with the American Diabetes Association on March 28, 1974, according to Dr. Martin G. Blechman, President. This means that the state organization will have nonprofessional representation on its board of directors and will engage in public solicitation of funds. Their activities will include implementation, support, and development of research and professional, patient, and public education. Ms. Frances Tasner is Executive Director of the New Jersey affiliate, whose offices are located at 345 Union Street, Hackensack 07601.

MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

Sept.

Clinical Endocrinology
11 3:30 p.m.—Martland Hospital, Newark Beth
18 Israel, and VA Hospital, East Orange (varies)
25 *(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)*

Orthopedic Surgery
14 8:30 a.m.—Martland Hospital, Newark
21 *(Sponsored by CMDNJ, New Jersey Medical*
28 *School and Academy of Medicine)*

10 **Renal Failure**
10 a.m.—North Hudson Hospital, Weehawken
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

12 **Urinary Tract Infections**
8-9 p.m.—Mount Holly Medical Center
(Sponsored by the Burlington County Medical Society and Academy of Medicine)

13- **Inflammatory Bowel Disease**
15 Playboy Club, Great Gorge
(Sponsored by National Foundation for Ileitis and Colitis, New Jersey Gastroenterological Society and Academy of Medicine)

13- **Cardiovascular Care Conference**
15 Haddon Hall, Atlantic City
(Sponsored by American Heart Association and Academy of Medicine)

18 **Gun Shot Wounds**
10 a.m.—St. James Hospital, Newark
(Sponsored by Academy of Medicine)

18 **Cardiac Arrhythmias**
1:30 p.m.—Runnells Hospital, Berkeley Heights
(Sponsored by Academy of Medicine)

18 **Renal Failure**
6 p.m.—Bridgeton Hospital, Bridgeton
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

19- **Electrocardiography Workshop**
22 Cherry Hill Inn, Cherry Hill
(Sponsored by AAFP)

19 **Nephrology Conference**
1:30-5 p.m.—Rutgers Medical School, CMDNJ, Piscataway
(Sponsored by Nephrology Society of New Jersey, New Jersey Regional Medical Program, and Rutgers Medical School, CMDNJ)

20 **Clinical Endocrinology**
12 noon—Freehold Hospital
(Sponsored by Academy of Medicine)

24 **Acupuncture**
11 a.m.—Greystone Park Psychiatric Hospital
(Sponsored by Academy of Medicine)

24 **The Lymphocyte and its Clinical Significance**
8-10 p.m.—Englewood Hospital Englewood
(Sponsored by Englewood and Holy Name Hospitals and Academy of Medicine)

24 **Cardiac Action of Drugs**
6-9 p.m. (Dinner meeting)—Ramada Inn, Clark
(Sponsored by New Jersey Society of Anesthesiologists and Academy of Medicine)

24 **Renal Failure**
1 p.m.—Trenton Psychiatric Hospital, Trenton
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

25 **Plasma Lipoproteins and Disease**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

26 **Renal Failure**
9 a.m.—South Elizabeth Hospital, South Elizabeth
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

Oct.

1 **Immunology and Cancer of Head and Neck**
6-10 p.m.—Pascack Valley Hospital, Westwood
(Sponsored by Bergen County Society for Otolaryngologists and Academy of Medicine)

2 **Rapid Control of Violent Patient**
10:30-12 noon—Essex County Hospital Center, Cedar Grove
(Sponsored by Essex County Hospital and Academy of Medicine)

2 **Reducing Risk of Heart Attack and Stroke**
9 a.m.-3:30 p.m.—Sheraton-Poste Inn, Cherry Hill
(Sponsored by Camden County Heart Association and Academy of Medicine)

2 **Endocrine Emergencies**
9 **Metabolic Acidosis and Related States**
16 **Thyroid Problems in Practice**
23 **Sexual Dysfunction**
30 **Neonatal Medicine**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

4-6 **Cancer in Childhood and Adolescence**
Playboy Club, Great Gorge
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

4 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

5 **Orthopedic Surgery**
12 8:30 a.m.—Martland Hospital, Newark
19 *(Sponsored by CMDNJ, New Jersey Medical*
26 *School and Academy of Medicine)*

9 **Psychodynamics and Treatment of Male Homosexuality**
8-10 p.m.—Englewood Hospital, Englewood
(Sponsored by Academy of Psychoanalysis of New Jersey and Academy of Medicine)

10 **Myocardial Infarction**
8-9 p.m.—Deborah Heart and Lung Center. Browns Mills
(Sponsored by Burlington County Medical Society and Academy of Medicine)

11- **Annual Convention—AAFP**
14 Los Angeles, California

15- **Review of Obstetrics**
18 Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School)

15 **Renal Failure**
1 p.m.—Ancora Psychiatric Hospital, Hammonton
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

16 **Renal Failure**
9:30 a.m.—Bergen Pines Hospital, Paramus
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

16 **Renal Failure**
10 a.m.—St. James Hospital, Newark
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

23 **Rheumatic Diseases Workshop**
9 a.m.-3 p.m.—Rutgers Medical School, Piscataway
(Sponsored by New Jersey Rheumatism Association and AAFP)

Nov.

2 **Orthopedic Surgery**
9 8:30 a.m.—Martland Hospital, Newark
16 *(Sponsored by CMDNJ, New Jersey Medical*
23 *School and Academy of Medicine)*
30

6 **Clinical Endocrinology**
13 3:30 p.m.—Martland Hospital, Newark
20 *(Sponsored by CMDNJ, New Jersey Medical*
27 *School and Academy of Medicine)*

6 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, Academy of Medicine)

6 **Early Complications of Pregnancy**
13 **Hypothalamic Releasing Factors**
20 **Chemotherapy of Cancer**
27 **Disorders of Lower Esophagus**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

9 **Surgical Symposium**
9-12 noon—Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and Academy of Medicine)

13 **Hyperlipidemia**
8:30-10 p.m.—East Orange General Hospital
(Sponsored by East Orange General Hospital and Academy of Medicine)

13 **Death and Dying**
9-10:30 p.m.—Veterans Administration Hospital, East Orange
(Sponsored by Lewis H. Loeser Memorial Foundation and Academy of Medicine)

13 **Regional Meeting, American College of Physicians**
Rutgers Medical School, Piscataway

14 **Diagnostic Ultrasound**
8-9 p.m.—Mount Holly Medical Center
(Sponsored by Burlington County Medical Society and Academy of Medicine)

16 **Diabetes Today and Tomorrow**
9:30 a.m.-5 p.m.—St. Michael's Medical Center, Newark
(Sponsored by N.J. Diabetes Assn. and AAFP)

19 **Medical-Legal Aspects of Surgery and Anesthesiology**
6-9 p.m. (dinner meeting)—Ramada Inn, Clark
(Sponsored by New Jersey Society of Anesthesiologists and Academy of Medicine)

Dec.

4 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

4 **Clinical Endocrinology**
11 3:30 p.m.—Martland Hospital, Newark Beth Israel,
18 and VA Hospital, East Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

4 **Office Proctology**
11 **Androgen and Virilizing Syndromes**
18 **Mineralocorticoid Hypertension**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

7 **Annual Meeting, New Jersey Chapter, ACS**
Morristown Memorial Hospital, Morristown

1975
Jan.

4 **Orthopedic Surgery**
11 8:30 a.m.—Martland Hospital, Newark
18 *(Sponsored by CMDNJ, New Jersey Medical*
25 *School, and Academy of Medicine)*

8 **Drug Management of Coronary Arterial Disease**
15 **Portal Hypertension**

22 **Inflammatory Bowel Disease**
29 **Common Disease of Travelers**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

8 **Clinical Endocrinology**
15 3:30 p.m.—Martland Hospital, Newark Beth Israel,
22 and VA Hospital, East Orange (varies)
29 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

10 **Portal Hypertension**
12 noon-4:30 p.m.—Hamilton Hospital, Trenton
(Sponsored by Hamilton Hospital)

14 **Renal Failure**
8 p.m.—Paul Kimball Hospital, Lakewood
(Sponsored by Paul Kimball Hospital and Academy of Medicine of New Jersey)

21 **Cardiac Surgery and Anesthesiology**
6-9 p.m. (dinner meeting)—Ramada Inn, Clark
(Sponsored by New Jersey Society of Anesthesiologists and Academy of Medicine)

Feb.

1 **Orthopedic Surgery**
8 8:30 a.m.—Martland Hospital, Newark
15 *(Sponsored by CMDNJ, New Jersey Medical*
22 *School, and Academy of Medicine)*

5 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

5 **Clinical Endocrinology**
12 3:30 p.m.—Martland Hospital, Newark Beth Israel,
19 and VA Hospital, East Orange (varies)
26 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

5 **Common Protozoal and Fungal Infections**
12 **Future of Allergy**
19 **Hemostasis**
26 **Hypercalcemia and Hyperparathyroidism**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

Mar.

1 **Orthopedic Surgery**
8 8:30 a.m.—Martland Hospital, Newark
15 *(Sponsored by CMDNJ, New Jersey Medical*
22 *School, and Academy of Medicine)*
29

5 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 **Clinical Endocrinology**
12 3:30 p.m.—Martland Hospital, Newark Beth
19 Israel, and VA Hospital, East Orange (varies)
26 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

5 **Heart Block and Syncope**
12 **Renal Failure**
19 **Resuscitation in Shock and Trauma**
26 **Office Urology**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

Apr.

2 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

2 **Common Errors in Practice**
9 **Medical Hypnosis**
16 **Functional Diseases**
23 **Interaction of Drugs Used in Cardiac Disease**
30 **Stroke Rehabilitation**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

2 **Clinical Endocrinology**
9 3:30 p.m.—Martland Hospital, Newark Beth Israel,
16 and VA Hospital, East Orange (varies)
23 *(Sponsored by CMDNJ, New Jersey Medical*
30 *School, and Academy of Medicine)*

5 **Orthopedic Surgery**
12 8:30 a.m.—Martland Hospital, Newark
19 *(Sponsored by CMDNJ, New Jersey Medical*
26 *School, and Academy of Medicine)*

May

3 **Orthopedic Surgery**
10 8:30 a.m.—Martland Hospital, Newark
17 *(Sponsored by CMDNJ, New Jersey Medical*
24 *School, and Academy of Medicine)*

7 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 **Clinical Endocrinology**
14 3:30 p.m.—Martland Hospital, Newark Beth Israel
21 Medical Center, and VA Hospital, East Orange
28 (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 **Minor Surgery in Office Practice**
14 **Learning Disabilities**
21 **Nutrition of the Aged**
28 **Emotional Aspects of Common Medical Problems**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital)

June

4 **Clinical Endocrinology**
3:30 p.m.—Martland Hospital, Newark Beth Israel Medical Center, and VA Hospital, East Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 **Orthopedic Surgery**
8:30 a.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

OBITUARIES

Dr. Abraham Collis

Abraham Collis, M.D., of Middletown, died on July 25, 1974 at Riverview Hospital in Red Bank. Born in 1911, Dr. Collis received his M.D. degree from LaVal University in Quebec in 1943, and after service in the medical department of the AUS during World War II, he opened an office in Long Branch in 1946. In 1955, he began a three-year residency in radiology at the University of Cincinnati General Hospital and became board certified in that specialty. He had been on the staff in the department of radiology at South Amboy Memorial Hospital, Point Pleasant Hospital, and at the Woodbridge State School. Dr. Collis was a member of the Radiological Society of North America and the New Jersey Radiological Society.

Dr. Carmine Falcone

While vacationing in Italy, Carmine Falcone, M.D., a member of our Middlesex County component, died on July 14, 1974, following a brief illness. Born in Italy in 1894, Dr. Falcone earned his medical degree at the University of Naples Medical School in 1921 and spent a year at the New York Eye and Ear Clinic before coming to New Brunswick to establish a practice in general medicine. He had been on the staff at Middlesex General and St. Peter's Hospitals in New Brunswick. Dr. Falcone was recipient of MSNJ's Golden Merit Award in 1971. Two sons are practicing physicians—Dr. Italo Falcone, formerly of New Brunswick and now living in Italy, and Dr. John Falcone of East Brunswick.

Dr. Edward Hurtado

On June 30, 1974, Edward Hurtado, M.D., one of Middlesex County's senior members, died at Kennedy Medical Center in Edison. Born in 1895 in Bogota, Colombia, South America, where he received his medical degree from the Medical College of the National University of Colombia in 1918, he emigrated to the United States for internship at Hahnemann Medical College in New York (now New York Medical College—Flower Fifth Avenue Medical Center), followed by a three-year residency in orthopedics at the New York State Orthopedic Hospital in West Haverstraw, New York. Succeeding a decade of private practice in his chosen specialty, with concomitant teaching appointments at New York Polyclinic and St. Luke's Hospitals and Women's Medical College in New York, Dr. Hurtado accepted a full-time appointment in industrial medicine with Standard Oil of New Jersey and later with Colombia Petroleum and DuPont. From 1947 to 1965 he was Medical Director of the Student Health Center at Rutgers University. Since retiring from that position, Dr. Hurtado had been in semi-retirement, but maintained offices for part-time general practice in Metuchen. He was a member of the honorary staff at Middlesex General Hospital. His professional associations included the American Industrial Hygiene Association and the American College of Hospital Administrators. In 1968, Dr. Hurtado was a laureate of MSNJ's Golden Merit Award.

Dr. Concetta Mango

On June 5, 1974, Concetta Mango, M.D., one of Hudson County's well-known general practitioners, died at her home after a long illness. A graduate of Trinity College in Washington, D.C., she earned her medical degree from the University of Rome in 1936, and after internship at the Jersey City Medical Center, opened an office for general practice in North Bergen. Dr. Mango was North Bergen Township physician for over a decade and held staff appointments at Christ Hospital in Jersey City and at North Hudson Hospital in Weehawken. She is remembered by many for her gratuitous devotion to caring for the poor and elderly in the North Hudson area.

Dr. Vincent T. McDermott, Sr.

One of Camden County's senior practitioners, Vincent T. McDermott, Sr. died on July 23, 1974 at Our Lady of Lourdes Hospital in Camden, where he had been chief of staff before retirement from active practice. Dr. McDermott was graduated from Jefferson

Medical College in 1926 and had practiced internal medicine in the Camden area for many years. He was active in medical society affairs and had served a term as President of the Camden County Medical Society in 1961. Dr. McDermott was 74 years old at the time of his death.

Dr. Francis E. Proctor

One of Trenton's well-known practitioners, Francis E. Proctor, M.D., died on July 23, while vacationing at Rehoboth Beach, Maryland. A 1921 graduate of Jefferson Medical College, Dr. Proctor came to Allentown, New Jersey from Delaware in 1924 and three years later moved to Trenton to establish a practice in gynecology. He was on the staff at The Mercer Hospital in Trenton, progressing to Chief of Gynecology, an appointment he held for many years until retirement from active practice in 1967. He was Past President of the Mercer County Medical Society and was a Fellow of the American College of Surgeons. Dr. Proctor was 77 years old at the time of his death.

Dr. Abraham G. Reinfeld

One of Essex County's senior members, Abraham G. Reinfeld, M.D., died on June 15, 1974 at Beth Israel Medical Center, where he had been a long-time member of the staff in the Department of Otolaryngology. Born in Austria in 1892, Dr. Reinfeld came to the United States as a child and received his doctor of medicine degree from the University of Pennsylvania in 1916. He did graduate work at the University of Vienna and at the University of Bordeaux. He had practiced in Newark for over thirty years and in Maplewood for fifteen years before retiring to Irvington. He was a Fellow of the American College of Surgeons and, in addition to his association with Beth Israel Medical Center, he was on the staff at Newark Eye and Ear Infirmary and at the old City Hospital. Dr. Reinfeld was a Captain in the AUS during the first World War.

Dr. Milton R. Silon

Milton R. Silon, M.D., health officer for the City of Hoboken, and a member of our Hudson County Medical Society, died at Lenox Hill Hospital in New York on June 20, 1974. A life-long resident of Hoboken, Dr. Silon had been appointed health officer in 1947 and did much to streamline the city's health programs and expand the services to the residents. He was involved in creation of the public health nursing service and directed the daily operations of the health department, in addition to maintaining a private practice in general medicine. Born in 1911, Dr. Silon was graduated from the University of Iowa Medical School in 1936. During World War II, he was a flight surgeon in the U.S. Army Air Force and saw active duty for many months in the Pacific theater. He had been on the staff at the North Hudson Hospital in Weehawken, and was a member of the American Public Health Association.

Dr. Gerald W. Sinnott

Word has just been received of the death on March 16, 1974, of a former administrator of the Jersey City Medical Center, Gerald W. Sinnott, M.D. Born in 1909, Dr. Sinnott earned his bachelor's degree from Notre Dame and his doctor of medicine degree from McGill University in 1937 and spent all of his professional life in administrative medicine. During World War II, he was in the U.S. Public Health Service. He had been a director of the Sister Kenny Foundation and was instrumental in setting up the eastern clinic. In 1954 he accepted administrative appointment to the Medical Center in Jersey City. He was a Fellow of the American College of Hospital Administrators.

Dr. Belford A. Weeks

On June 13, 1974, Belford A. Weeks, M.D., a member of our Atlantic County component, died after a brief illness. Born in 1919 and a 1937 graduate of Temple University School of Medicine, Dr. Weeks was a general practitioner in Absecon for many years. He had been on the staff at Shore Memorial Hospital in Sommers Point and was a member of the American Rheumatism Association. Dr. Weeks was a medical officer in the AUS for four years during World War II.

BOOK REVIEWS

Treatment of Cardiac Emergencies. Emanuel Goldberger, M.D. Saint Louis, Mosby, 1974. Pp. 355. Illustrations 231. (Softback—$14)

The public concept of ultra modern medical care is best represented by the drama of cardiovascular emergencies. Until very recently, people frequently died of these dread syndromes. It is vital for primary care workers to become knowledgeable in this area in order to save lives.

This book succeeds admirably in presenting its subject logically in a clear, step-by-step exposition. Divided into three parts, the book describes the syndromes, the cardio-respiratory equipment, and the medications used in treatment.

The authors indicate their own biases and preferences but do justice to other opinions. While their presentation is complete, the authors admirably take a stand on what they think is best.

Your reviewer recommends the book to all from student to specialist, both medical and surgical. The entire ER, ICU, and CCU team including ancillary workers will be able to follow the reasoning and learn.

Norman Riegel, M.D.

General Pathology. Walter, J. B. and Israel, M. S. Longman, New York (Churchill Livingston Medical Division, London, 1974) Pp. 681. Illustrated. ($32.50)

Walter and Israel have produced a clinical and physiological story of general pathology which is a gem. Modern, concise, and readable, the text merits review or study by every student, practitioner, and hospital administrator. The chapter on hospital infections should be required reading for every member of a hospital staff and Board of Trustees. The illustrations are well selected and aid in comprehension of the text. The chapters are short, with the exception of the sections on tumors and blood, and are clinically informative. The text is a brilliant contrast to the voluminous description of anatomical lesions usually designated as required reading for the student.

Not all phthisiologists will accept the statement (P-84-C2-L1) that "tubercle bacilli do not commonly reach the front of the mouth, and it is very unlikely that droplets are an important vehicle of their spread."

The reviewer was unable to gain the author's concept with regard to posthepatic cirrhosis. There were such statements as: "there is no evidence that the condition follows hepatitis" (P-123-C2-L8), or "occasionally massive necrosis may follow, and the patient either dies or else is left with macronodular cirrhosis" (P-289-C1-L8). Again, (P-289-C2-L14) "Furthermore its course is more benign, there being a higher death rate and a much greater incidence of cirrhosis in serum hepatitis." Perhaps, in a controversial field, ambiguity is wisdom. Hepatitis virus destruction is best accomplished by 30-minute boiling not 10 minutes at 100°C (P-637-C2-L20). Most neuropathologists regard meningococcic exudate as classically cortical as opposed to basal involvement by tuberculosis (P-228-C2-L22).

If this text could be read a chapter a day by all embryo and practicing physicians, the level of medical care would be improved throughout the land. To the title of "General Pathology" the reviewer would add the accolade of "Modern General Pathology," a commendable volume.

Thomas K. Rathmell, M.D.

Creative Aggression. G. R. Bach, Ph.D. and Herb Goldberg, Ph.D. New York, Doubleday, 1974. Pp. 407. ($8.95)

Written in a fresh and easy style that lends itself to casual reading, this book appears to have been prepared for consumption by the general public, and with proper promotion, may become a best seller. It is filled with concise, factual material pertaining to aggression and its importance in interpersonal and intrafamilial relationships.

The book is divided into three parts. The first part is concerned with people, and the second, with society. The third portion presents some techniques in living constructively with aggression. Each one of these sections is well organized, and describes a substantial number of everyday situations. The third section describes some therapeutic techniques that may not be orthodox in their approach, but are interesting. An example is the use of the Bataca, which is a club-shaped pillow used to act-out aggression. An added feature is a chapter on the management of intra-office relationships.

This is not a reference text, nor is it of substantial value to the clinical psychiatrist, but it is a good book for physicians in other fields to read (for both pleasure and purpose). It will provide considerable insight into the role of aggression in everyday relationships.

Seymour F. Kuvin, M.D.

Questions and Answers on Death and Dying. Elisabeth Kubler-Ross, M.D. New York, Macmillan, 1974. Pp. 177. (Paperback—$1.50)

This is a timely and humane book composed in seminar fashion. It is a sort of supplement to the author's 1960 publication "On Death and Dying" and deals with questions that arise at her seminars. These concern mainly the stages of denial and isolation, anger, bargaining, depression, and acceptance into which the author divides the behavioral reactions of the dying patient who has been informed of his plight. In today's world of chemicals and apparati devised to prolong life that so often drag out the processes of death in peculiarly mechanical fashion, there is great need for expertise in patient and family management, support, and ongoing psychotherapy, as well as prophylaxis. There is, too, great need for moral evaluation on the part of the profession. Much of the author's approach is constructive. Some of the answers to questions are platitudinizing but always tender. It comes as something of a surprise on page 170 to discover that the author has never charged a terminally ill patient nor his family, regardless of the financial situation. It would seem that the author, as a teacher of students and graduate physicians, must meet that aspect of professionalism that demands a professional to place a tangible value on his services.

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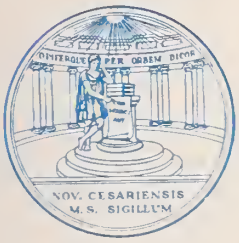

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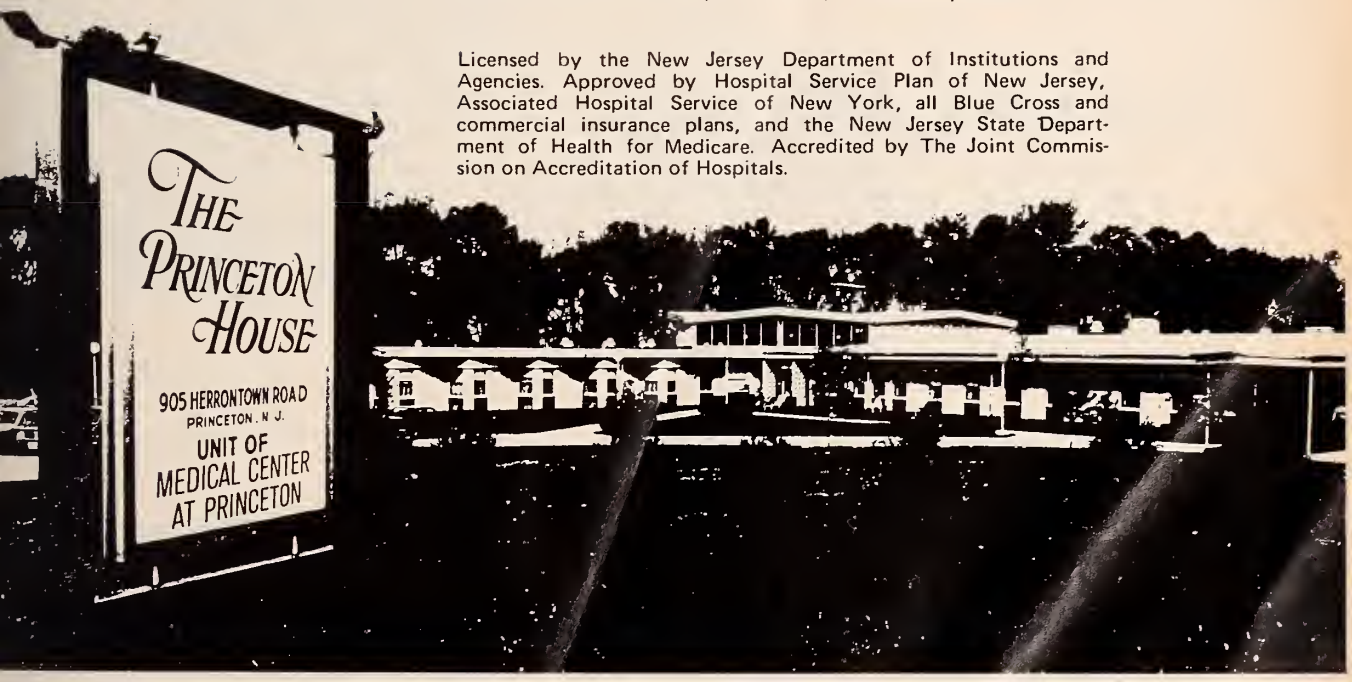

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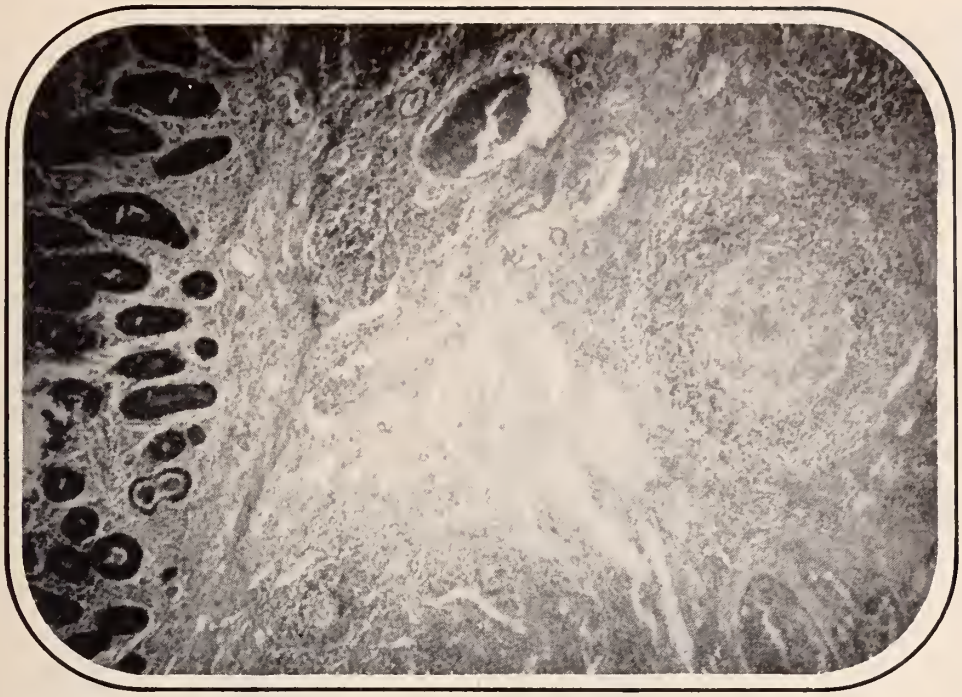

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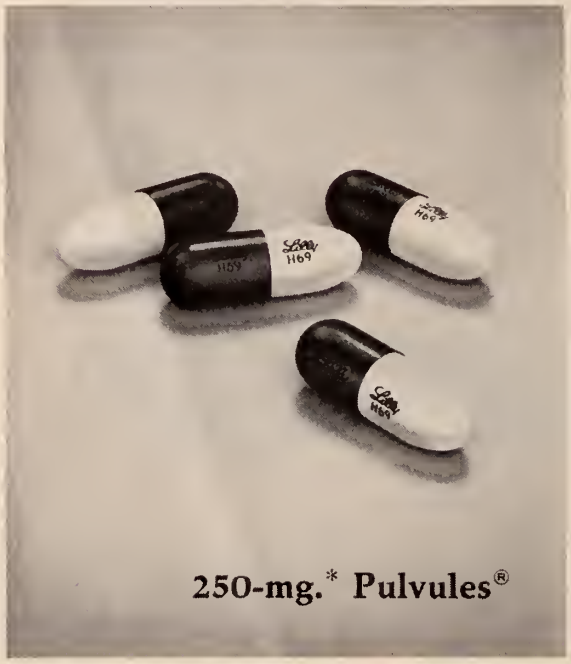

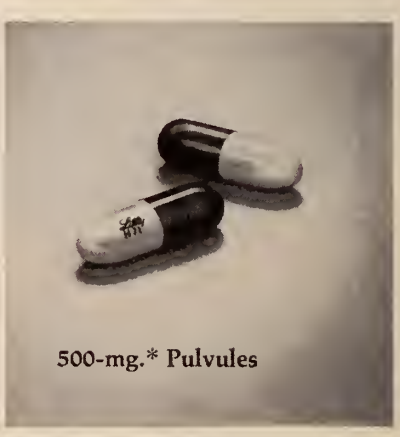

*Equivalent to cephalexin.

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EDITORIALS

October: Immunization Action Month

MSNJ and the New Jersey State Department of Health have joined the AMA, the USPHS, and a host of national medical, public health, nursing, and industrial organizations in the promotion of Immunization Action Month (IMA). We urge all New Jersey physicians to join in this cooperative effort to halt and reverse an alarming and potentially catastrophic situation.

National studies in 1973 showed declining immunization levels among children aged one to four years against poliomyelitis, measles, rubella, mumps, diphtheria, pertussis, and tetanus in the United States. In our own State, Joanne E. Finley, Commissioner of Health, reported that the measles outbreak of this past school year was the worst since licensure of the measles vaccine. There were 5,700 reported cases, half of them involving teenagers! Over 200 victims required hospitalization.

Here is what you should do—

1. Develop an immunization audit of each child in your practice.

2. Review your office records and the immunization status of the children with their parents.

3. Encourage parents to obtain specific immunization where a deficiency is found.

4. Pay particular attention to the one to four-year-age group, but don't forget the teenagers.

5. Remember the overall objective of IAM: immunize a minimum of 90 percent of the susceptible pre-school children against measles, rubella, poliomyelitis, diphtheria, tetanus, and pertussis by the time they have entered first grade.

(See page 775, this issue, for immunization schedule recommended by the American Academy of Pediatrics.) A.K.

New Annual Meeting Site

Cherry Hill, New Jersey will host the 209th Annual Meeting of MSNJ, May 31 to June 3, 1975. After a great deal of thought and investigation, the decision has been announced by the Annual Meeting Committee, with the concurrence of the Executive Committee and the Board of Trustees.

We applaud this outcome for many reasons: new hotel accommodations, convenient location, availability of fine convention facilities, and pleasant social, recreational, and entertainment resources. The Cherry Hill Hyatt House, scheduled for opening the end of this year, will be the headquarters locale.

A major incentive for this relocation is a desire to enhance our usual attendance with many of the 6,500 physicians in our Society who have never visited the annual meetings in Atlantic City. We believe the change in environment, as well as creative and innovative convention techniques, has the potential to magnetize our colleagues, along with medical students, interns, and residents. Enlightenment of future generations of practitioners about medicine and surgery in our State and the adducements of The Medical Society of New Jersey will be a fringe benefit.

Our heartiest congratulations to the decision-makers. We hope to see you in Cherry Hill next spring.

A.K.

Is There a Gap?

One of the most forceful arguments for the development of Health Maintenance Organizations (HMO's) has been the reputedly increasing gap between available ambulatory health care services by primary physicians and the demand for those services. Is this real or the imaginary figment from hostile media, conniving unions, community pressure groups, and government agents rushing head-

long into national health insurance?

One may blurt out an emotional response instantly—No! No Gap!!—or one may think rationally and realistically before coming to a conclusion. Essentially there are three kinds of supportive evidence which can be utilized on either side of the argument. One may review existing national and state statistics dealing with numbers of doctors, population basis, health institutions, and the like. There is anecdotal data, essentially consisting of personal experiences related by patients, citizen organizations, individual physicians, social agencies, and even medical society committees. Finally, there are specific demographic studies in selected regions of the state. These studies, by qualified personnel, are being used in conjunction with federal planning and development grant applications by burgeoning HMO's.

A look at such information is interesting. Rates of physicians on a national basis indicate a bit over one physician per thousand population, with a breakdown as follows:

General or family practice	0.26
Medical specialties	0.30
Surgical specialties	0.36
Other specialties	0.31
Total	1.23

One finds communities which do not meet these standards (which are not necessarily optimal), e.g.

Weehawken (pop. 13,383)	0.89
Kearny (pop. 37,585)	0.91
North Bergen (pop. 47,751)	1.03
Jersey City (pop. 260,545)	1.0
Bayonne (pop. 72,743)	1.1

Some communities seem to have enough primary physicians, but a shortage of specialists. In others, the reverse is true. Physician age is another factor. In one study, covering a population base of over 600,000, there were only 0.82 physicians per thousand, with a median age for family practitioners of 59 and for general surgeons of 58. Median ages were even higher in some specialties. This places a significant group at or close to retirement.

Anecdotal data from interviews and questionnaires from persons who do not have a personal primary physician are often used to substantiate the difficulty of obtaining medical care. The problem is more complex among the undereducated and the persons with a language barrier. Hospital emergency department statistics are probably a more valid indicator and speak rather eloquently to the point. More and more emergency departments have employed full-time practitioners to meet the ever-increasing demand for services, while a large proportion of emergency department visits are for non-emergency conditions, ostensibly because the patient does not have or cannot find a physician or because his physician is not available.

Like the three blind men who describe an elephant after palpating certain parts of its anatomy, the question of a "gap" depends on one's vantage point and his built-in prejudices. In any case, the answer is "yes" and "no." In some areas, there is an absolute shortage of primary physicians and specialists. In other areas, there is a relative shortage, i.e., the demand for services exceeds the ability of private practitioners to provide them, when and where patients want such services. Some doctors reluctantly refuse to add new patients to their practices because of the ever-present struggle between quantity and quality medical care. Others are so overwhelmed dispensing "crisis care," that they have little time to practice preventive medicine.

The problem in New Jersey as everywhere seems to be an increasing demand for health services of all types by a health-conscious population, coupled with mal-distribution of physicians. As the median age of physicians rises, and retirements occur, young medical graduates are not appearing in the community to take over. This is especially true in the highly populated urban communities.

Will HMO's solve these problems and close the gap? Probably not entirely; only time will tell. A.K.

ORIGINAL ARTICLES

DIC, a life-threatening complication of pregnancy, can be recognized by clinical and laboratory evidence, including fibrinogen consumption and the PPP test. Treatment of the primary disease and the use of heparin, fresh-frozen plasma, and whole blood replacement are discussed. The special problems of postpartum hemolytic uremia, the complications of intra-amniotic injection of hypertonic saline, and coagulation changes in toxemia are also described.

Disseminated Intravascular Coagulation in Pregnancy

Howard Smith, M.D., Caterina A. Gregori, M.D., and James L. Breen, M.D./Livingston

Disseminated intravascular coagulation accounts for only a small proportion of the total hemorrhagic complications of pregnancy with an incidence of three to five per thousand pregnancies.[23] However, when this does occur, it is a most dramatic and often disastrous event. Referred to initially as an afibrinogenemia, or a hypofibrinogenemia, these acquired clotting defects are now assigned other terms, reflecting the increased understanding of the clotting mechanism. Presently, a "disseminated intravascular coagulation" is the most accepted term to describe a generalized or systemic activation of the clotting mechanism beyond that of local clotting *per se*. It is our purpose to discuss disseminated intravascular coagulation as related to the pregnancy state of the female.

Most of our knowledge about disseminated intravascular coagulation in pregnancy is related to studies on premature separation of the placenta.[1] The first description of a hemorrhagic diathesis in pregnancy was made by De Lee in 1901 when he wrote about "acquired hemophilia" in a patient who had an abruptio placentae.[17] About 1919, the Japanese developed the concept that placenta must have some toxic property that caused toxemia.[26] Obata showed that injection of placental extract into an animal would cause death.[17] Sakurai, in 1929 demonstrated that placental extract injections would defibrinate dogs.[17] In 1936, Diekmann studied cases of abruptio and found that the "fibrin" was characteristically below 200 mg percent—significantly lower than in a normal pregnancy.[7] In 1947, Kellogg presented a series of abruptio cases that featured a rapidly developing hemorrhagic diathesis and proposed the concept that, in severe degrees of abruptio placentae, the decidua was disrupted and thromboplastin allowed to enter into the circulation with resulting defibrination.[11] In the next year, the concept firmly developed that the bleeding tendency, in abruption, was due to a lack of fibrinogen.

During the Korean War, there was a tremendous effort to fractionate plasma, and human fraction I or fibrinogen was isolated.[17] The Boston Lying-In Hospital took the lead in the use of fibrinogen, and in 1953, Reid, Weiner, and Roby described the treatment of three patients with fibrinogen:[22] one had a severe abruption, another a dead fetus syndrome, and the third, an amniotic fluid embolism. Reid and his associates related all these events to defibrination.

Schneider, in 1951 in a paper on defibrination,[24] used the term "disseminated intravascular coagulation," and this concept was also proposed by McKay.[17] An argument then en-

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sued as to whether the reduction in fibrinogen was due to its lysis by active fibrinolysin, subsequently called plasmin, or whether it was consumption coagulopathy.[17] Through the work of Nilsen[16] and with the elucidation of the coagulation schema and the ability to measure coagulation factors, it became apparent that a homeostatic failure leading to a consumption coagulopathy was the mechanism operational in a host of hemorrhagic diatheses in various disease entities. The nature and significance of the alterations in the coagulation system, however, are still being debated.

Physiology of Hemostasis

To fully comprehend the mechanism of disseminated intravascular coagulation, a short review of the physiology of clot formation is necessary. For descriptive purposes, hemostasis may be divided into three components: the vascular phase, the platelet phase, and the coagulation phase.[10]

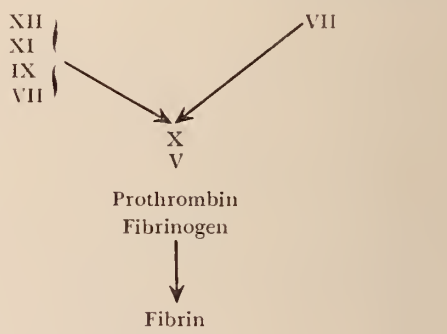
The Vascular Phase—The most immediate consequence of small vessel insult is a reduction of blood flow, a result of vasoconstriction and extravasation of blood. These virtually instantaneous phenomena are quickly supplemented by the events of both the platelet and coagulation phases which are initiated by the process of contact activation and by the release of various substances from the injured tissues.

The Platelet Phase—Within seconds after the initial insult, the platelets begin to adhere to the surface of the injured vessel and then agglutinate to one another. This process is greatly facilitated by the retarded blood flow. The processes of platelet adhesion and aggregation are complex and poorly understood. However, like the injured vessels, the agglutinating platelets play both a mechanical and biochemical role in hemostasis with the release of various substances which are involved in the coagulation phase. The most important of these are various phospholipids, collectively termed "platelet factor 3," which become active in coagulation even before the platelet membrane is visibly altered.

The Coagulation Phase—The mechanism by which the coagulation factors interact is still uncertain. Evidence suggests that they are proenzymes which are normally inert, but which are transformed into proteolytic enzymes when activated, each sequentially activating the proenzyme next in line. Calcium is essential for most steps in the coagulation process, but remarkably little is known concerning its mechanism of action.

There are two operational systems during the coagulation phase (Figure I). The extrinsic

Figure I
Operational Systems During Coagulation Phase



system is initiated by the release of tissue thromboplastin as the site of tissue disruption. On the other hand, the intrinsic system is initiated by contact of factor XII with some substance, probably exposed collagen. Both systems are united at factor X and factor V; prothrombin and fibrinogen are required for both mechanisms.

The final step in the coagulation phase involves the transformation of fibrinogen to fibrin which is the physical basis of all blood clots. This occurs in three separate steps: (1) the enzymatic proteolysis of fibrinogen by thrombin; (2) the formation of a visible, but unstable, fibrin polymer termed soluble fibrin; and finally, (3) the formation of a stable fibrin polymer termed insoluble fibrin as a result of the action of factor XIII or fibrin stabilizing factor.

Mechanisms which maintain the normal

fluidity of the blood restrict the process of hemostasis to the site of the injury. The physiologic inhibitors of coagulation are poorly understood substances which neutralize the various enzymes produced during blood coagulation, and thus, prevent the propagation of the thrombus beyond the site of insult. They include the antithrombins, the antithromboplastins, prothrombinase inhibitors, and numerous others.

Fibrinolysis is usually considered the major physiologic means of fibrin disposition, after its hemostatic function has been fulfilled. Fibrinolysis is accomplished by leukocytes and the fibrinolytic system in which plasmin, a proteolytic enzyme, is activated to destroy fibrin. If plasmin is activated, in amounts which exceed the capacity of the antiplasmins to neutralize it, other proteins in the plasma, including fibrinogen and most of the coagulation factors, may be destroyed. The process that initiates coagulation also initiates fibrinolysis, by the activation of a polymer of factor XII, termed factor XIIA. These relationships are fundamental when homeostasis is threatened by intravascular coagulation.

Pregnancy as a Hypercoagulable State

The definition of the term "hypercoagulable state" is controversial. Some investigators define it as a state during which high levels of certain coagulation factors could be found, while others feel that it must be used only to indicate a state during which there is an increased tendency toward intravascular coagulation. Pregnancy fulfills both of these definitions.

Analysis of coagulation factors by such investigators as Kasper, Markarian, Bleyer, and Breckenridge[2,12,19] all demonstrate increased levels of fibrinogen, prothrombin and factors VII, VIII, IX, and X. Bleyer[19] also demonstrated higher levels of factor XII at the time of delivery; however, this remains unsubstantiated by other investigators.[19] Although it is generally felt that factor V remains constant during gestation. Bleyer[19] reported somewhat elevated levels at delivery, while Markarian[12] had a slightly low mean figure during labor.[12]

There has been recent interest in factor XI levels in the pregnant patient in whom decreasing concentrations of factor XI have been reported as gestation progresses.[1,19] This decrease in factor XI levels could be a dilutional effect due to hypervolemia during pregnancy, to a decreased or inadequate rate of synthesis, or to an overutilization of factor XI.[1]

Coopland, *et al.*[5] have shown that factor XIII, the fibrin stabilizing factor, also decreases significantly during pregnancy, for probably the same reasons given for factor XI. The drop in factor XIII may have particular significance.[19] Since fibrinogen increases during pregnancy, there may be a threefold increase in the ratio of fibrinogen to the fibrin stabilizing factor. It is not yet known whether or not this results in a less stable clot; however, this remains a possibility.[1]

Not only is there an increase in coagulation factors during pregnancy, but the pregnant patient also has operational certain mechanisms protecting her against the disastrous results of disseminated intravascular coagulation and thromboembolic disease, namely her fibrinolytic system.[19,21] During gestation, the plasminogen levels increase above the normal range, although the levels of fibrinolytic inhibitors increase. However, the pregnant patient has a potentially effective fibrinolytic system that can be activated, in response to intravascular coagulation, to remove fibrin depositions and arrest clotting.[19,21]

We have now come full circle in response to the question of pregnancy as a hypercoagulable state. Increased levels of fibrinogen, prothrombin, factors VII, VIII, IX, X and fibrinolytic inhibitors tend to augment the potential of intravascular coagulation; whereas, decreased concentrations of factors XI and XIII may help to counteract this augmentation as does the enhancement of the plasminogen system in pregnancy.

Four Types of Intravascular Coagulation

To understand the pathology of intravascular coagulation in pregnancy, it is necessary to

define the major types of intravascular activity that are related to a host of disease entities in which disseminated intravascular coagulation is manifested.

Acute disseminated intravascular coagulation occurs as a result of procoagulated material entering the circulation and causing conversion of fibrinogen to fibrin and aggregation of platelets.[1,14,15] This is sometimes, but not always, accompanied by the formation of a thrombus. The process causes activation of the fibrinolytic enzyme system that results in the degradation of fibrinogen and fibrin, to fibrin split products.[1,4] This activity is associated with a marked vasomotor alteration in the form of shock. The episode is not over until the coagulation system and the vasomotor apparatus have returned to normal, and the last fibrin split product has been cleared from the circulation.

Acute disseminated intravascular coagulation has multiple etiologies.[15] Among them are: intravascular hemolysis; a release of tissue thromboplastin, presence of bacterial endotoxins; activation of proteolytic enzymes; antigen-antibody complexes; complement, particulate or colloid material; anoxia, endothelial damage; viruses; abnormal vasomotor activity; alpha-adrenergic stimulation, hypertension; lipids and free fatty acids.

In a single massive intravascular clotting episode, there is a decrease in platelets, fibrinogen, factors V, VII, VIII, IX, X and often factor XIII. If the patient survives, the factors return to normal; however, there is an "overshoot" that occurs after the initial return to normal, and this leads to a hypercoagulable state and a possible second acute episode.[1,4,15]

Besides the consumption of these clotting factors by the coagulation process throughout the body, the fibrinolytic enzyme system is activated and releases fibrin split products into the circulation. At the same time that clotting is going on, soluble fibrin is present in increased amounts in the blood. Soluble fibrin, consisting of partly polymerized fibrinogen, can be demonstrated in the circulating blood by exposing it to cold, to alcohol, or to protamine sulfate.[1,4,9,18] This is evidence of intravascular coagulation.

An important feature that should be emphasized is that, although the coagulation factors go down to the same extent during the drop, after the overshoot they return to normal at varying times. This is because they have different half-lives and different rates of synthesis. As a consequence, a patient's fibrinogen level may be normal when, in fact, the patient may have active intravascular coagulation occurring.[1,4,15]

Hypotension is one of the best signs of an acute massive intravascular coagulation episode.[4,15] The hypotension is not entirely due to the clotting, but it is almost always present, due essentially to the obstruction of the flow of blood in the pulmonary circulation with a diminished return to the left heart. The bleeding tendency is another frequent, but by no means invariable, occurrence, and many patients have disseminated intravascular coagulation without evident bleeding.[4,10,15]

Acute local intravascular clotting refers to coagulation that usually occurs in only one organ system.[15] For example, the kidney in a patient with hyperacute rejection of a renal graft is almost totally infarcted due to acute local fibrin deposition in the glomeruli. The changes in the hemostatic mechanism are the same as in acute disseminated intravascular clotting; therefore, it is impossible to differentiate between these two conditions by the test tube. These patients do not necessarily go into shock. The difference between this entity and the systemic counterpart is one of degree. Removing the organ in which the acute intravascular clotting is occurring cures the patient. The dead fetus syndrome may be considered as an acute local intravascular coagulation defect for there is a sufficient local deposition of fibrin in the placenta to lower the clotting factors to a point of depletion.[15] When the placenta is removed, the patient recovers immediately.

In chronic intravascular coagulation, the hemostatic changes are apparently paradoxical, in contrast to those seen in acute intravascular coagulation. Chronic intravascular clotting implies a long duration low-grade intravascular coagulation in response to a small stimulus.[15] There may be a succession of several small intravascular coagulation episodes in which fibrinogen and factors V, VII, VIII and X at first decrease as they do in the acute massive episode. Each of the small episodes is followed by recovery and an "overshoot." Eventually with repeated clotting, the levels of fibrinogen and of the other clotting factors do not drop below normal, but rather begin to fluctuate above normal values. In addition, a paradoxical alteration is seen in the number of platelets which, instead of rising above normal, usually remain factors. In addition, fibrin degradation products appear as well as soluble fibrin and incompletely polymerized fibrin.[1,4,15]

In what diseases is there chronic intravascular clotting? Thrombotic thrombocytopenic purpura, postpartum hemolytic uremic syndrome and pre-eclampsia/eclampsia are only three in a long list of clinical entities.[15] Normal pregnancy is the outstanding example of chronic *local* coagulation. This condition embraces all the alterations that are characteristic of chronic intravascular coagulation, but they occur only in the placenta of a normal pregnancy.[15]

Laboratory Determination of Intravascular Coagulation

As previously stated, normal pregnancy is accompanied by an elevation of certain clotting factors which may increase the tendency toward intravascular coagulation. Providing a female does not suffer from any antecedant hematologic disorder, such as thrombotic thrombocytoxemia, purpura, or primary thrombocythemia in which placelet abnormalities exist, those tests which measure overall hemostasis such as bleeding time, platelet counts, adhesiveness, and aggregation should be unchanged in a normal pregnancy.

The partial thromboplastin time (PTT) is unaffected by platelet abnormalities and is essentially a measurement of factors IX, X, XI and XIII.[4,9] A shortening of the PTT below the normal range is believed to be an indication of the presence of circulating serum factors above normal levels. In pregnancy, factors IX and X are elevated, while factors XI and XIII are decreased. As expected, in normal pregnancy, the PTT is shortened in approximately one-third of women, prolonged in one-third, and unchanged in one-third.[21] The PTT, however, is a significant tool to study hypo- or hypercoagulability.

The clotting time is basically a measurement of the Hageman factor activation, which sets in motion the clotting cascade, with factor XI, to form activated surface factor[4,9] The presence of activated surface factor in circulating plasma indicates that the early phases of the intrinsic clotting system have been triggered. Because the Hageman factor (XII) levels are generally accepted as normal in pregnancy, then so is the clotting time.[21]

The prothrombin time (PT) is a measurement of the "prothrombin complex" consisting of factors II, VII, IX and X.[4,9] The Quick prothrombin time also measures factor V. Because factors II, VII, IX and X are elevated in normal pregnancy, the prothrombin time is also shortened as a result in most patients.[21]

In hemorrhage due to any obstetrical complication, all of the above tests will be altered as a result of blood loss. To make the diagnosis of intravascular coagulation, one must measure fibrinogen consumption or degradation and the appearance of soluble fibrin monomers in the circulation. When fibrinogen is acted upon by thrombin, fibrinopeptide A and B are split off and the remaining fibrin monomers then polymerize to form a clot.[10] This, in turn, is acted upon by factor XIII to change the polymer from a soluble to an insoluble clot. In conditions in which there is an excess of fibrin deposition, fibrin monomers which are soluble accumulate locally and within the circulation. Recent assays to describe their presence (ethanol gelation and serial dilution protamine tests) are

difficult to reproduce, but when positive, are a specific indication that fibrinogen has been converted intravascularly to fibrin.[9,18,21]

When fibrinogen is acted upon by fibrinolysin and many other proteolytic enzymes, a series of degradation products are found, and these are collectively termed fibrinogen degradation products or FDP. The same step occurs, irrespective of whether fibrinolysis is primary as in shock, or secondary to the prior activation of coagulation. The difference is only one of degree. It is influenced by rates of removal of the FDP through the reticuloendothelial system and liver. The measurement of fibrinogen degradation products in serum are extremely inaccurate, and sensitive tests have only recently been standardized.[9,24]

The best available method to measure soluble fibrin monomers is the plasma protamine paracoagulation test (PPP).[19] This is a less sensitive, but a more practical method than the serial dilution protamine test. A precipitate is gradual from 0 to 5 plus after 0.1 ml. of protamine sulfate has been incubated with 1 ml. of plasma for fifteen minutes. It is not yet certain what the significance of 1 or 2 plus grading is; however, the 3 and 4 plus grades have a high correlation with intravascular coagulation as defined both clinically and by the dilutional protamine method.

Therapy in Disseminated Intravascular Coagulation

The mode of presentation of the syndrome of disseminated intravascular coagulation is variable, but not every patient requires therapy directed at the specific abnormality in hemostasis. Patients who have balanced or compensated consumption coagulopathy, despite a precarious hemostatic mechanism usually do not have serious bleeding, unless they are surgically challenged. It is presently accepted that proper therapy for these patients is directed at their underlying disease rather than at a correction of the hemostatic mechanism. On the other hand, when the process is more fulminant, and life-threatening bleeding or hemorrhage are present, specific and rapid therapy is warranted. In virtually every case, the initiating stimulus is primarily the result of activation of the coagulation mechanism and the activation of the fibrinolytic mechanism is a secondary and compensating reaction. It has been strongly suggested that specific therapy in these patients should be directed primarily at the intravascular coagulation. Many investigators have shown that the administration of heparin to patients with acute disseminated intravascular coagulation may lead to the rapid restitution of clotting factors toward normal.[27] On the other hand specific therapy directed exclusively at the fibrinolytic system may destroy the compensatory balance achieved between thrombin and plasmin and lead to fulminant fibrin deposition; therefore, it is now generally accepted that there are few, if any, indications for the isolated use of agents that inhibit the fibrinolytic mechanism, such as epsilon-amino-caproic acid.[6,21,27]

Disseminated intravascular coagulation is always secondary to an underlying pathologic process that serves as the trigger and therapy can only be successful insofar as it is directed at the primary disease. There is little doubt that we are recognizing this syndrome with increasing frequency, and that we now have available patients and effective therapy. What is less certain are the criteria for initiating anticoagulant therapy. There are some disorders, such as gram negative septicemia and endotoxic shock, which have such a high prevalence of disseminated intravascular coagulation that some investigators hold that all such patients should be treated prophylactically. Others believe that only patients in whom signs of shock develop are threatened by disseminated intravascular coagulation, and that therapy should be confined to these patients. Still others think that by the time shock has developed, therapy may be too late.

After adequate heparin has been given, the consumed clotting factors may be replaced with fresh frozen plasma, although this is rarely necessary because of the vigorous use of whole blood replacement in most patients.[21] As a useful rule, each unit of whole blood or frozen plasma raises the fibrinogen concentra-

tion 25 mg percent. Fibrinogen concentrates are dangerous and should be avoided, if at all possible, because of the high incidence of hepatitis following their use. Further, the rapidity with which the body produces fibrinogen when under stress suggests that the greater problem is one of impairment of homeostasis and autoregulation.

If fibrinogen must be used, it should be used in conjunction with heparin[21] to prevent the deposition of new fibrin. If heparin therapy is stopped before the underlying disease has been fully controlled,[21,27] a second episode of intravascular coagulation may occur.

Postpartum Hemolytic Uremic Syndrome

The postpartum hemolytic uremic syndrome is a rare clinical entity which must be distinguished from postpartum eclampsia.[8] This syndrome used to be called postpartum renal failure, postpartum hypertension, or postpartum nephrosclerosis. Ordinarily, these patients have had a normal antenatal course and an uncomplicated delivery.[23] The onset of the syndrome usually occurs three days to ten weeks after delivery. A prodome of mild gastrointestinal disturbance, mild fever, upper respiratory complaint and anemia occurs; the initial complaints may be related to the anemia, including fatigue, weakness and edema. There is a bleeding tendency: purpura, easy bruising, and ecchymoses. Eventually, these patients almost always develop acute renal failure.

They have an active intravascular coagulation of the chronic systemic type, and all the criteria for chronic intravascular coagulation are met.[23] The pathologic findings indicate that two different disease processes are involved. The kidneys are severely damaged and show the characteristic hyperplasia of the arteriolar smooth muscle layer that we associate with essential hypertension rather than toxemia. Occlusive masses of fibrin cling to the walls of the hyperplastic vessels. The arcuate artery branching in the renal cortex is virtually closed by what is essentially an organized thrombus. Once renal failure occurs, it is generally irreversible; death from renal failure occurs if these patients are not dialyzed. The intravascular coagulation in this case is insidious, and the disease is very rarely diagnosed early enough for therapy to be initiated. Clarkson of Melbourne, Australia did a study of nine cases of postpartum hemolytic uremic syndrome. Three patients with DIC were treated with heparin,[6] but none responded; by the time the disease was diagnosed, the renal arteries were already thrombosed.

Changes in Maternal Coagulation Factors After Intra-Amniotic Injection of Hypertonic Saline

The use of intra-amniotic hypertonic saline has become a popular method for inducing abortion during the second trimester of pregnancy but serious reactions and maternal deaths have been reported due to accidental intravasation of the hypertonic solution. Deaths that occur several hours after injection may not be due to this mechanism.

In discussing 13 deaths that occurred in Japan after the intra-amniotic injection of hypertonic saline, Wagatauma indicated that some were the result of uncontrolled uterine hemorrhage.[26] He also found that a certain number of deaths took place several hours after the intrauterine injection and were preceded by a shock syndrome. Later studies in patients who were therapeutically aborted with hypertonic saline demonstrated a marked decrease in plasma fibrinogen a few hours after the saline injection but before the onset of regular uterine contractions. There was also a decreased platelet count, decreased factor VII and, most important, evidence of a soluble fibrin monomer. This suggested that there is activation of the coagulation mechanism and that intravascular coagulation was occurring.[3,26] There also appeared to be a concomitant mild activation of the fibronolytic system as indicated by decreased profibrinolysin and fibrinolytic inhibitors.[3,26] These changes began as early as three hours after intra-amniotic infusion and became more extensive after 24 hours. During the entire period, the hematocrit remained stable or actually increased by one to two volumes percent. In 1,500 saline

infusions studied at the Harlem Hospital Center and Columbia University,[3] these changes were apparent in all cases. However, only one clinical problem that could be associated with either thrombosis or hemorrhage was observed in any of the patients studied. This attests to the efficiency of the equilibrium maintained by the coagulation—fibrinolytic mechanism during pregnancy. Nevertheless, the results suggest that an occasional patient may develop more pronounced changes.

Changes in Maternal Coagulation Factors in Toxemia

Evidence from recent research on toxemia suggests that part of the disease process is related to disseminated intravascular coagulation. The pathway of the activation of the coagulation mechanism is still undetermined. Platelets, fibrinogen, prothrombin time and factors, V, VII and X were investigated in a total of 104 toxemia patients, 61 normal pregnancies and 7 eclamptic patients by Galton, *et al.*[8] of Dartmouth Medical School. There was no significant change in these blood coagulation factors in the peripheral circulation, even in the severe pre-eclamptic patients, when compared with the normal pregnant controls. There was also no change in patients with severe pre-eclampsia who were followed, in sequence, over several weeks until delivery. This finding is in contrast to that in eclamptic patients. Four out of seven of this group had intravascular coagulation, including the most severe form in a patient who died in eclampsia. It is believed, at this time, that pre-eclampsia may represent a chronic intravascular coagulation defect. As soon as the patient becomes eclamptic, the disseminated intravascular coagulation may no longer be self limited. McKay, *et al.*[14] found evidence of intravascular coagulation at autopsy in 9 out of 10 eclamptic patients. It is difficult to theorize whether the eclampsia is a result of an exaggerated process of intravascular coagulation or whether the intravascular coagulation is the result of, rather than the etiologic factor for, the eclampsia.

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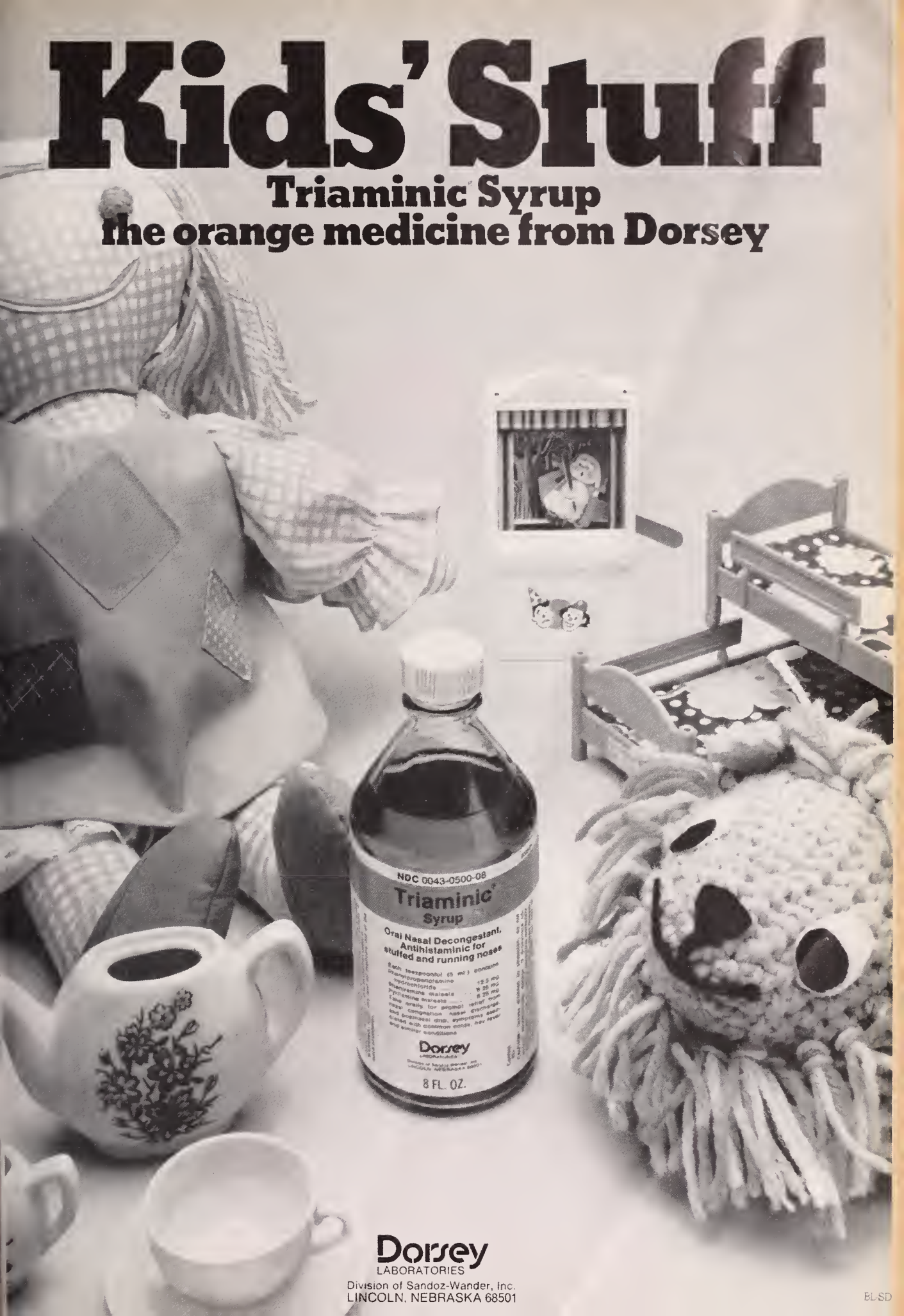

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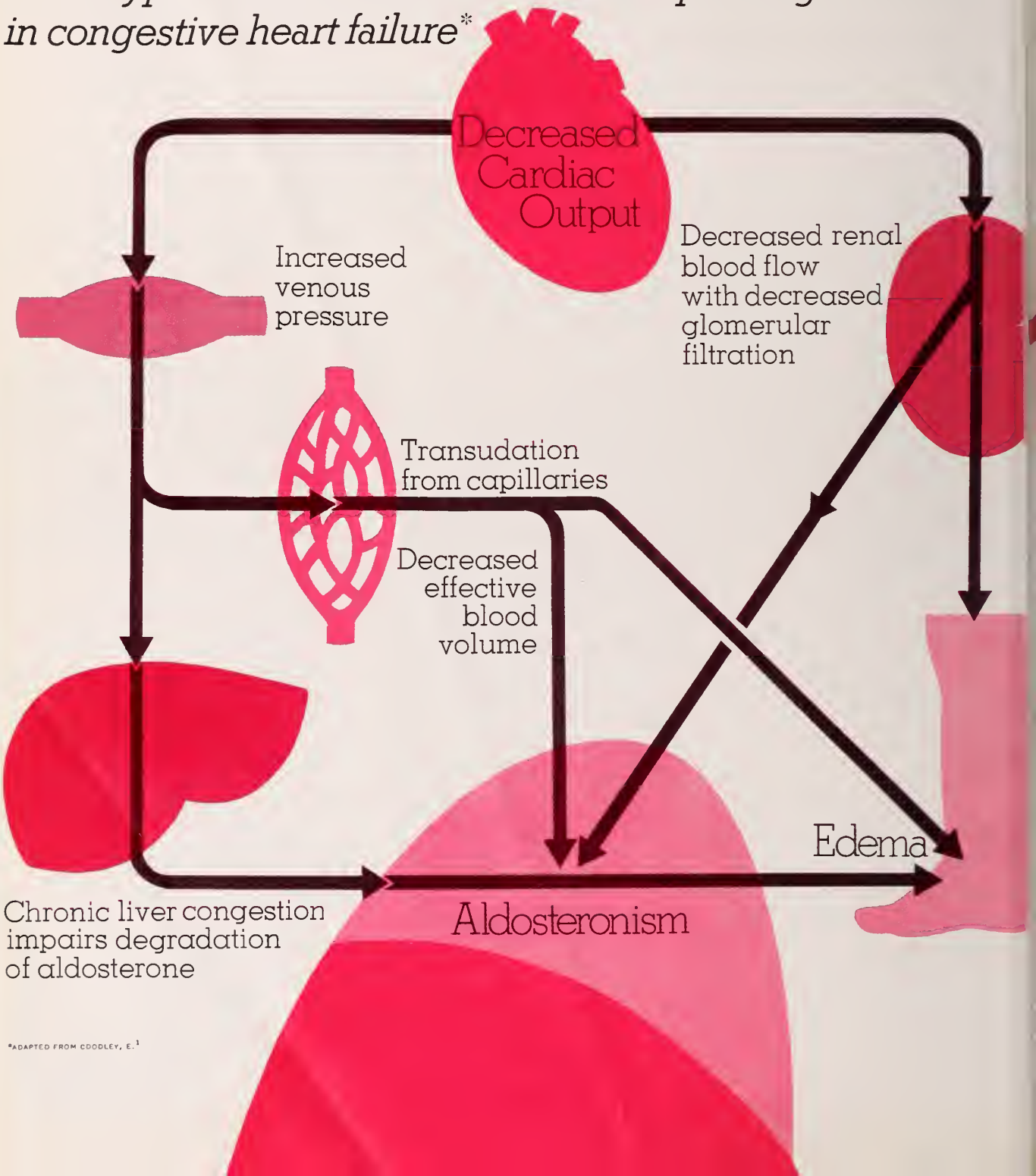

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Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephratic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

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The Role of the Detail Man

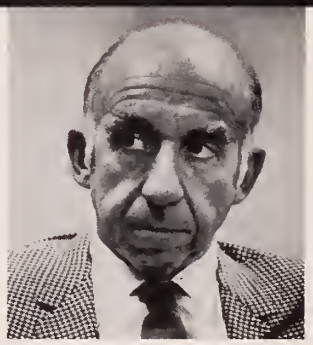
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I an very much in favor of the detail me I meet. Most of them are knowledge able about the drugs they promote and can be a great help in acquaint ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this countr there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center research people, and academic people have and that's in all likelihc on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

He a Source of Information?

Yes, with certain reservations. ıe average sales representative s a great fund of information out the drug products he is re- onsible for. He is usually able to swer most questions fully and telligently. He can also supply prints of articles that contain a eat deal of information. Here,), I exercise some caution. I usu- y accept most of the statements d opinions that I find in the pers and studies which come m the larger teaching facilities. goes without saying that a physi- an should also rely on other urces for his information on armacology.

aining of Sales Representatives

Ideally, a candidate for the sition as a sales representative a pharmaceutical company ould be a graduate pharmacist ıo has a questioning mind. I don't nk this is possible in every case, d so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

pacity they are indeed useful; rticularly in the fact that they sseminate broadly based educa- nal material and serve not just "pushers" of their drugs.

e Other Side of the Coin

Obviously, the pharmaceuti- companies are not producing all s material as a labor of love— y are in the business of selling ducts for profit. In this regard ambitious and improperly moti- ed sales representative can ert a negative influence on the acticing physician, both by pre- nting a one-sided picture of his duct, and by encouraging the actitioner to depend too heavily drugs for his total therapy. In se ways, the salesman has often torted objective reality and dermined his potential role as an ucator.

e Industry Responsibility

Since the detail man must be information resource as well as epresentative of his particular armaceutical company, he ould be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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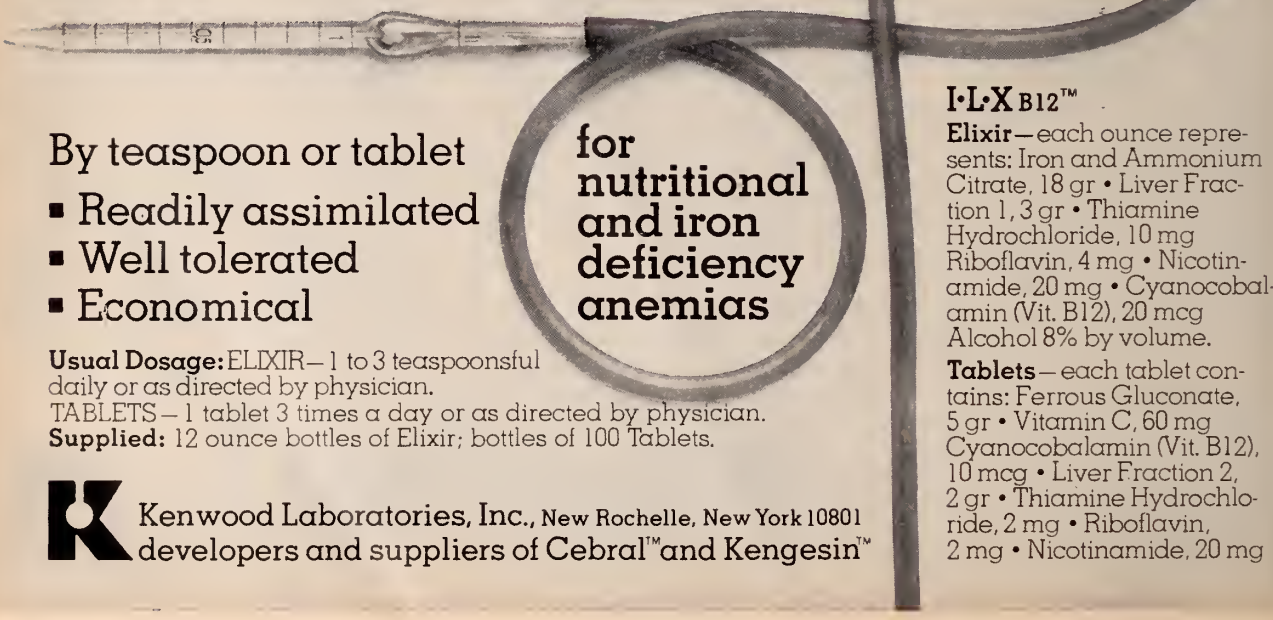

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A group of adult epileptic patients receiving anticonvulsant drug therapy were shown to have reduced mean serum calcium and elevated serum alkaline phosphatase levels. The authors ascribe these changes to a drug-induced osteomalacia.

Alterations in Calcium Metabolism Due to Anticonvulsant Medication

Martin N. Herman, M.D., et al.
Long Branch*

In 1968, Kruse[1] first reported alterations in calcium metabolism occurring among treated epileptics and suggested that anticonvulsants might be causal. The serum changes of hypocalcemia and elevated alkaline phosphatase have since been amply documented.[2,3,4] More importantly, radiographic features of osteomalacia in adults[5,6] and clinical rickets in children[7,8,9] have been reported. Since the initial report, drugs in the phenylurea, hydantoin and barbiturate classes have all been implicated.[2]

These studies, inexplicably, have received scant attention in the American neurologic literature. To call attention to this relationship and to investigate the possible causal role of other medications, particularly phenothiazines, the following study was carried out.

Methods

To determine if significant alterations in calcium metabolism existed in an anticonvulsant treated group of epileptics, a pilot study was carried out. The study group included 37 institutionalized adult epileptics on anticonvulsant therapy for greater than one year and 37 nonepileptic inpatients residing in a regional Veterans Administration Hospital. No attempt at matching the two groups was made.

The following criteria were prerequisites for inclusion in this study: a stable weight over the last year, the absence of a history of recurrent diarrhea, a normal urinalysis and normal values of blood urea nitrogen (BUN), creatinine, serum glutamic oxaloacetic transaminase (SGOT), total bilirubin, total protein and cholesterol. The epileptic patients were receiving one or more of the following anticonvulsant drugs: diphenylhydantoin (DPH), phenobarbital, mephenytoin, trimethadione, and primidone. The most common drug regimen was DPH and phenobarbital as shown in Table 1. Many of the epileptics were receiv-

Nonproprietary and Trade Names of Drugs

Diphenylhydantoin—Danten®, Dihycon®, Dilabid®, Dilantin®, Ekko®, Toin®
Mephenytoin—Mesantoin®
Trimethadione—Tridione®
Primidone—Mysoline®
Phenacemide—Phenurone®
Chlorpromazine—Thorazine®
Thioridazine—Mellaril®
Isoniazid—INH®
Diazepam—Valium®
Propoxyphene—Darvon®

Table 1
Anticonvulsant Regimens

Drugs	*Number of Patients*
DPH only	3
DPH + phenobarbital	28
DPH + phenobarbital + primidone	2
DPH + primidone	1
Primidone only	1
Phenobarbital + mephenytoin	1
DPH + phenobarbital + trimethadione	1

*This work is from the Neurology Service of the Veterans Administration Hospital, East Orange, and the Department of Neurosciences, CMDNJ, New Jersey Medical School, Newark. Coauthors are Richard H. Blanck, M.D., Stuart M. Applebaum, B.A., and William K. Cors, B.A.

Table 2

Medication	*Number of Individuals*
multivitamins	4
B Complex	1
pyridoxine	1
folic acid	2
ferrous fumarate (Ferro-Sequels®)	1
propoxyphene (Darvon®)	5
diazepam (Valium®)	6
glutethamide (Doriden®)	1
chloral hydrate	2
dioctyl sodium sulfosuccinate (Colace®)	1
dioctyl calcium sulfosuccinate (Surfak®)	1
ampicillin (Omnipen®)	1
sulfamethoxazole (Gantanol®)	1
nitrofurantoin (Furadantin®)	1
lincomycin hydrochloride (Lincocin®)	1
isoniazid (INH)	1
dexamethasone (Deroni®)	2
digoxin	1
hydrochlorthiazide (Hydrodiuril®)	1
tolazoline hydrochloride (Priscoline®)	1
papaverine hydrochloride (Pavabid®)	1
imipramine hydrochloride (Tofranil®)	1
thiothixene (Navane®)	1
chlorpromazine (Thorazine®)	9
thioridazine (Mellaril®)	11

ing, in addition, a variety of other medications as listed in Table 2. Fasting blood samples were drawn from each patient and values for serum calcium, alkaline phosphatase, inorganic phosphate, sodium, potassium, chloride, carbon dioxide, BUN, creatinine, glucose, total bilirubin, total protein, albumin, cholesterol, lactic dehydrogenase (LDH), SGOT, creatine phosphokinase (CPK), and uric acid were determined using the Technicon Autoanalyzer.® All tests were run on the same machine on the same day. The mean values for each group were compared for statistically significant differences using the standard Student "t" test.

A second study was designed to determine the effect of phenothiazine medication on serum alkaline phosphatase and calcium levels. Difficulties were encountered in trying to match phenothiazine medications exactly as two drugs, thioridazine and chlorpromazine, were in wide use in the population. The authors hypothesized that the effect of these two medications would be the same. To test this hypothesis a chlorpromazine vs. thioridazine test was designed as follows: the original 37 institutionalized anticonvulsant treated epileptics were divided into three groups. Group A consisted of 17 patients receiving anticonvulsants alone; Group B consisted of 9 patients receiving anticonvulsants plus chlorpromazine, and Group C consisted of 12 patients receiving anticonvulsants plus thioridazine. The mean values for serum calcium and alkaline phosphatase were then compared using a BMD biomedical computer program for analysis of variance for one-way design[10] and Student "t" test.

A third study, the control study, compared nine of the original epileptic patients from the institutionalized population with nine nonepileptic patients from the same institution. Control subjects were screened for absence of malabsorption and hepatic or renal disorders as previously described. The groups were matched for the following criteria: sex, age by decade, duration of institutionalization, diet, estimated time outdoors, ambient ultraviolet ward radiation and presence or absence of phenothiazine medication.

The average age of the epileptic group was 48.3 years and that of the nonepileptic group 47.6 years. Each group consisted of five men and four women. Seven were Caucasian and two were Negro in each group. The average duration of institutionalization was 7.2 years in the epileptic group and 10.3 years in the nonepileptic group. Eight members in each group were receiving phenothiazines in equivalent doses.

Fasting blood samples were then analyzed for the serum constituents as in the pilot study and mean serum values analyzed for statistical significance using the Student "t" test.

Results

The results of the pilot study in which 37 epileptics taking anti-convulsants were compared with 37 veterans not taking anticonvulsants are displayed in Table 3. The mean serum calcium in the epileptic group was 9.2 mg. percent and in the veterans 9.8 mg. percent. This difference was highly significant ($p = 0.001$). In 8.2 percent of the epileptics the serum calcium was abnormally low. The mean serum alkaline phosphatase was 118 international units (I.U.) in the epileptic group and 62 I.U. in the veterans. This difference

Table 3

Serum Constituent	*Epileptic Group* (mean value)	*Veterans Group* (mean value)	*Normal Range*	*Level of Significance*
Calcium mg/100 ml	9.2	9.8	8.5-10.5	p= .001
Alkaline Phosphatase I.U.	118	62	30-85	p= .001
Inorganic phosphate mg/100 ml	3.3	3.6	2.5-4.5	p= .05
CPK I.U.	135	156	0-110	NS
LDH I.U.	219	171	90-200	p= .01

was also highly significant (p = 0.001). More importantly the serum alkaline phosphatase was abnormally elevated in 67.6 percent of the epileptics. The mean serum inorganic phosphate level was 3.3 mg. percent in the epileptics and 3.6 mg. percent in veterans. This difference was also statistically significant (P=.05). The mean serum CPK level was 135 I.U. in the epileptic group and 156 I.U. in the veterans. Both values were abnormally high but the difference was not statistically significant. The mean serum LDH level was 219 I.U. for the epileptic group and 171 I.U. for the veterans. The value for the epileptic group was abnormally elevated and the difference between the two groups was significant (P=.01). The product of the serum Ca X P was below 30 (the lower limit considered necessary for normal bone mineralization[3]) in 37.8 percent of the epileptic group.

The results from the second study in which epileptics receiving anticonvulsants only were compared with those receiving anticonvulsants and chlorpromazine and those receiving anticonvulsants and thioridazine are displayed in Table 4. Using the BMD01V program for analysis of variance, the f ratio amongst the three groups showed no significant difference for mean serum values for calcium and alkaline phosphatase (D.F.=2,34; F=1.6569 for serum calcium and F=0.1780 for serum alkaline phosphatase).

In the third study, 9 epileptics receiving anticonvulsant medication were compared with 9 nonepileptic matched controls. The results are displayed in Table 5. The mean serum calcium was 9.4 mg. percent for the experimental group and 9.2 mg. percent for the controls. The difference was not statistically significant. The mean serum alkaline phosphatase was 123.3 I.U. as compared with 63 I.U. for the control group. This difference was

Table 5

Serum Constituent	*Experimental Group* (mean value)	*Control Group* (mean value)	*Level of Significance*
$\bar{x}$ Calcium mg/100 ml	9.4	9.2	NS
$\bar{x}$ Alkaline phosphatase I.U.	123	63.	p= .01
$\bar{x}$ Inorganic phosphate mg/100 ml	3.6	3.1	p= .05

significant (P=.01). The mean value of serum inorganic phosphate was 3.6 mg. percent for the epileptic group and 3.1 mg. percent for the controls. The difference was statistically significant (p=.05), but both values were within the normal range.

Discussion

Alterations of calcium metabolism in epileptic patients receiving long term anticonvulsant therapy were first reported by Kruse in 1968[1]. He suggested that hypocalcemia in treated institutionalized epileptics was related to dosage of anticonvulsant medication, to multiple drug therapy, and to duration of therapy.

Richens and Rowe examined the sera of institutionalized epileptics and found significantly elevated alkaline phosphatase and lowered serum calcium levels.[2] Isoenzyme study of the alkaline phosphatase revealed elevation of both bone and liver fractions but the hypocalcemia correlated most closely with the hepatic

Table 4

	Group A Anticonvulsant Only	*Group B Anticonvulsant and* Chlorpromazine	*Group C Anticonvulsant and* Thioridazine	*f ratio*	*Level of Significance*
Number of Patients	17	9	12		
$\bar{x}$ Ca mg/100 ml	8.9	9.4	9.3	1.6569	NS
$\bar{x}$ Alkaline Phosphatase I.U.	120.7	108.9	120	0.1780	NS

fraction. Other investigators, however, failed to document this correlation.[3,4]

In decreasing order, Richens and Rowe found the following anticonvulsants most likely to produce the serum changes: phenacemide, primidone, DPH and phenobarbital. However, as the authors themselves point out, the total dosage of drug, rather than any specific drug, seemed to correlate most closely with the lowered serum calcium. The data obtained by Hahn, *et al.*[4] support this relationship with total dosage while the results of Hunter, *et al.*[3] do not.

As the serum changes found are those usually occurring in osteomalacia, many investigators postulated an alteration in vitamin D levels.[2,3,5]

Vitamin D is a mixture of the fat soluble antirachitic substances vitamins D_2 and D_3. It is absorbed in the small intestine, transported to the liver and there metabolized to several biologically active forms, the most important being 25-Hydroxycholecalciferol ($250HD_3$) and 25-Hydroxyergocalciferol ($250HD_2$), the active metabolites of vitamin D_3 and vitamin D_2 respectively. The combination of $250HD_3$ and $250HD_2$ is referred to as 25-Hydroxycalciferol (250HC) and is responsible for elevating plasma calcium and phosphate to levels necessary for normal mineralization of bone.[11] In 1969 Ponchon and DeLuca demonstrated that the liver is the major site of hydroxylation of vitamin D_3 into $250HD_3$ which is subsequently released into the plasma.[12]

Both vitamin D and 250HC are structurally similar to steroids and hence degraded by the hepatic P-450 microsomal enzyme system responsible for the metabolism of steroid compounds.[4] As both DPH and phenobarbital are known to induce this enzyme system,[13] the original suggestion put forth by Richens and Rowe[2] and Dent, *et al.*[5] of vitamin D deficiency due to augmented catabolism has merit. Indeed, Hunter *et al.*, found a significant correlation between the concentration of D-glucaric acid, a quantitative index of hepatic enzyme induction, and serum calcium levels.[3]

Evidence in support of vitamin D deficiency has emerged. Haddad and Chyu directly assayed plasma 250HC and found decreased levels in patients on long term phenobarbital therapy.[14] Hahn *et al.* investigated the metabolism of radioactive vitamin D_3 in normal individuals receiving chronic phenobarbital therapy and found decreased vitamin D_3 half-life and increased conversion to metabolically inactive polar metabolites as well as 250HC.[7] In the same study hepatic microsomal fractions from control and phenobarbital treated rats were incubated with tritated vitamin D_3. In the latter, increased conversion to 250HC and polar nonactive metabolites occurred.

Shaefer investigated the intestinal absorption of vitamin D in rats receiving anticonvulsants and reported normal absorption.[15]

Most of the earlier human studies were carried out on institutionalized epileptics and were not controlled for the effects of other medications. Recently, Hahn *et al.* studied an outpatient epileptic population receiving only DPH and phenobarbital and demonstrated low serum 250HC levels in 33 percent. Further, they demonstrated a positive correlation between serum 250HC and serum calcium level.[4]

The results of the pilot study in this report demonstrate an elevation of serum alkaline phosphatase to abnormal levels in patients receiving anticonvulsant medications. Further, serum calcium levels, though within the normal range, were significantly lower than in a group of patients not taking anticonvulsants. The statistically significant elevation in LDH in the treated epileptic group has been noted by others but is as yet unexplained.[16]

The results of the pilot study do not conclusively implicate anticonvulsants as causal agents producing the serum changes, for the epileptic patients were also receiving a wide variety of other medications. Of the drugs listed in table one, those which may affect the hepatic P-450 enzyme system and interfere with the metabolism of anticonvulsants or steroid compounds are: (1) isoniazid (2) di-

azepam (3) propoxyphene and (4) phenothiazines.[17]

Isoniazid is known to raise DPH levels as a result of inhibition of DPH metabolism in approximately 10 percent of patients. Diazepam has been reported to elevate DPH levels in 4 patients but the great majority show no effect. Propoxyphene has been reported to elevate DPH levels in one patient receiving 600 mg. of the drug daily. Chlorpromazine and related phenothiazines are also reported to elevate DPH levels. In addition some patients develop hepatic hypersensitivity reactions to phenothiazines resulting in altered hepatic function.

To exclude the effects of other medications, a controlled study was done. Because of difficulties in matching for specific phenothiazine medication, thioridazine and chlorpromazine were considered to have equal effect on serum, calcium, and alkaline phosphatase levels. This hypothesis was tested in the second study and proved to be correct as no significant difference in serum calcium or alkaline phosphatase levels was found between those receiving anticonvulsants only, those receiving anticonvulsants and chlorpromazine, and those receiving anticonvulsants and thioridazine.

In the third study, nine institutionalized epileptic patients were carefully matched with institutionalized nonepileptic control patients to exclude the following factors as contributory to the genesis of altered calcium metabolism: (1) dietary intake of vitamin D, (2) estimated time outdoors, (3) ambient ultraviolet ward radiation, (4) other medications, particularly phenothiazines, (5) sex and duration of institutionalization.

No patient in either the experimental or control group was receiving isoniazid. Two patients in the experimental group and none in the control group were receiving diazepam. However, in the diazepam-treated experimentals, the DPH levels were below the normal therapeutic range suggesting no effect on DPH metabolism.

The results of this investigation indicate that the elevation of alkaline phosphatase in treated epileptic patients is a direct consequence of anticonvulsant therapy. The addition of either chlorpromazine of thioridazine to the therapeutic regime is without effect on calcium metabolism. Failure to demonstrate clinically significant hypocalcemia in the controlled study is not surprising in view of the small sample size and the low incidence of hypocalcemia in the epileptic population as a whole. However, this low incidence of hypocalcemia (8.3 percent) and very high incidence of elevated alkaline phosphatase (67.6 percent) was surprising as most studies have reported hypocalcemia in 19 percent[4] to 30 percent[3] and elevated alkaline phosphatase in only 24 percent[3] to 29 percent[2]. Although many reasons for this disparity may be speculated upon, the fact that these blood samples were obtained towards the end of the summer must raise the possibility that the serum changes reflected healing osteomalacia.

These findings are of more than academic interest. Rickets and tetany have been reported in children receiving long term anticonvulsant therapy[7,8,9] and osteomalacia with bone density changes in adults.[5,6], Dent, *et al.* suggested that drug-induced hypocalcemia might be expected to aggravate seizure activity regardless of the primary disorders but did not test the hypothesis.[5]

At present there is no way of clinically predicting which patients will develop the chemical changes, much less clinical disease though patients on multiple drug regimens, blacks, and persons with limited exposure to sunlight are probably most at risk. There does seem to be a correlation between serum 250HC levels and the appearance of clinical disease. Arnaud, *et al.* report a case of severe drug-induced osteomalacia with serum 250HC levels of 4 to 6 ng/ml.[18] Hahn, *et al.* state that levels less than 10 ng/ml might reflect early depletion of antirachitic stores.[4] Unfortunately, this test is not readily available. A more practical method is to follow serum alkaline phosphatase levels in all treated epileptics. The

exact duration of follow-up cannot be stated at present. A persistent rise in alkaline phosphatase in the absence of liver or bone disease should be taken as an indication of relative vitamin D deficiency and the patient watched closely for clinical disease.

Stamp, *et al.* administered $25OHD_3$ in two patients suffering from anticonvulsant induced osteomalacia with good result.[19] In one case, after treatment with $25OHD_3$, the improved clinical state was maintained with ultraviolet irradiation alone. Hence, in at least some cases this iatrogenic illness is reversible making the need for further research to identify the at-risk patient and the proper therapeutic regimen even more imperative.

Summary

A group of institutionalized adult epileptics receiving anticonvulsants was examined for alterations in calcium metabolism. A statistically significant lower mean serum calcium concentration and higher alkaline phosphatase was found in the epileptic group as compared to controls. Clinically significant hypocalcemia was found in 8.2 percent of the epileptics and clinically significant elevations of serum alkaline phosphatase in 67.6 percent. Using matched controls, other medications, particularly phenothiazines, were eliminated as a cause for these metabolic alterations. This study further confirms the entity of anticonvulsant induced osteomalacia. The clinical implications of this study are discussed.

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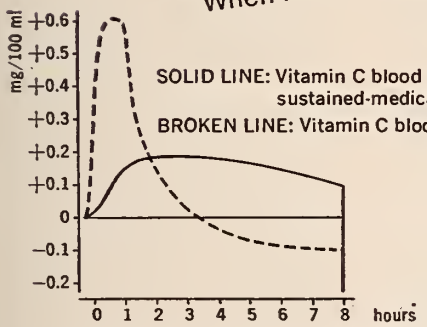

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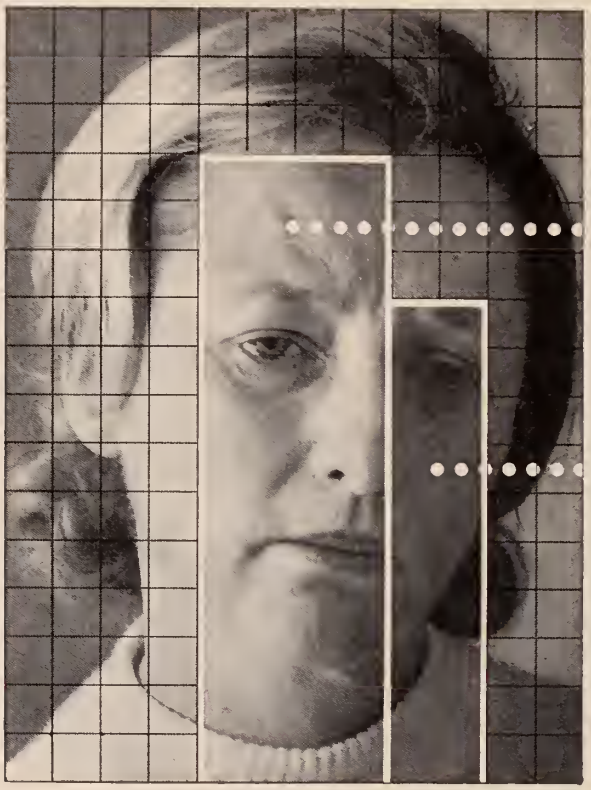

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For further information on this subject, the following references are provided:

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Headaches in children must be carefully classified in order to administer appropriate treatment. A thorough history, physical examination, and selected studies are essential. One then can decide whether the headache is vascular, allergic, functional, or secondary to systemic disease, an intracranial condition, or disease of the eyes, ears, nose, or dental structures.

A Review of Headaches in Children

M. H. Zanjanian, M.D./Passaic

Headache is a symptom seen in a great variety of conditions in children. Although the expression of headache is easy for the older child, it is not so in infants and young children under six years. The older children can even localize their headaches to various parts of the head, which may lead the physician to an accurate diagnosis. In infants and very young children restlessness, crying, holding and rubbing of the head, ear pulling and head rolling may imply headache; occasionally, the child may complain that his head hurts.

Children with chronic intermittent headache have been classified as either migrainous or nonmigrainous.[1] Among the nonmigrainous group, some etiologic factors to be considered are epilepsy, psychiatric problems, and neurological disorders such as minimal brain dysfunction, minor perinatal central nervous system damage, and previous head trauma or cerebral concussion. Various degrees of nervousness, mental instability, and immaturity, and conflicted home environment can be found in many children with prolonged intermittent headaches. Thus, psychogenic headache is frequent in this group.

In children with sudden onset of headache, or with progressively more severe headache, one should first think of systemic diseases and organic causes. Of course, in most such cases associated symptoms may help us to arrive at a diagnosis. Careful examinations and necessary laboratory work are essential in all cases to differentiate psychogenic from organic headache.

Classification

Many classifications of headache are available, including the one made by the Committee on Classification of Headache,[3] but all are incomplete, since the etiology and mechanism of many headaches is still unknown.[2] We would like to cite our classification which is shown in Table 1.

Table 1
Classification of Headache

I. Systemic Diseases:

a. Infection
b. Intoxication
c. Endocrine and Metabolic Disorders
d. Hypertension
e. Cerebral Hypoxia

II. Intracranial:

a. Increased Intracranial Pressure
b. Infection
c. Epilepsy

III. Vascular (Migraine Syndrome)

IV. Diseases of Ocular, Auricular, Nasal, and Dental Origin

V. Functional Disorders:

a. Tension or Muscle Contraction Headache
b. Psychogenic, Delusional, Conversion Headache

VI. Allergic Headache

Systemic Diseases

Systemic diseases cause headache by their secondary effects on cranial structure and function, such as vascular dilatation and edema. Infectious diseases are most commonly responsible for headaches in children. Fever, bacteri-

al endotoxins, and exotoxins cause cranial vascular dilatation resulting in headache. Headache is a manifestation of poisoning with carbon monoxide, phenol, benzene, nitrobenzene, nitrates, aniline, lead, and indomethacin (Indocin®).[4]

Idiopathic hypopituitarism may also be associated with headache, visual disturbances, vomiting, and occasionally diabetes insipidus, concomitantly. Of the metabolic disturbances, hypoglycemia may cause headache due to intracranial vasodilation. Hypertension, in patients with acute glomerulonephritis or pheochromocytoma, may cause headache.

Severe anemia and certain types of congenital heart diseases may cause headache due to cerebral hypoxia, while hemolytic crises in sickle cell disease or thalassemia may lead to episode headache.

Intracranial Diseases

Organic headache is due to distention and deformation of pain-sensitive blood vessels and meninges. The trigeminal nerve provides sensation for meninges of the supratentorial region. On or below the tentorium, upper cervical roots and ninth and tenth cranial nerves supply pain sensation. The pain from the supratentorial lesions is usually bifrontal, while the infratentorial lesions give suboccipital pain.

Headache due to increased intracranial pressure is dull, throbbing or bursting; it increases with change of position, e.g., bending over, or with straining at stool. Such headaches are severe in the morning, and improve in the afternoon. Increased intracranial pressure in infants and children is commonly due to tumor, but other space-occupying lesions include angiomas, subdural hematomas and collections, and abscesses. The headache associated with tumor tends to remit and exacerbate. Presumably the remissions are associated with transient accommodation of increased intracranial pressure by ventricular dilatation or spread of cranial sutures. Thus at one or more points in the course of the illness, headache will be absent for periods of time. Bacterial meningitis usually starts with severe headache which is usually generalized, and of course is associated with neck rigidity and other signs of meningitis. Encephalitis will also cause headache early in the course of disease, but the severity may be less than that with meningitis.

Headache is also seen in patients with epilepsy. On the basis of E.E.G. findings, these patients can be treated with anticonvulsant medications, although the subjects with a diffusely abnormal E.E.G. may not have a favorable prognosis.[1]

Vascular Headache

Vascular headache is the second most common form of headache in children, the first being "tension headache.[5] It is characterized by a pulsating headache, which may initially be unilateral. It is more common in females, and is accompanied or preceded by cortical sensory disturbances, often visual. Pallor, nausea and vomiting is associated, and frequently the attack is ended by an episode of vomiting. The child is incapacitated during these attacks, which interfere with normal activities. Although it is believed that vasodilatation causes the headache, other factors may trigger episodes including emotional tension and stress, physical exertion, special sensory stimuli (bright light, television, cinema, loud noise), ingestion of food containing tyramine or monosodium glutamate, drugs such as reserpine, exposure to high altitudes, and neurological conditions. The specific role of biological or chemical agents has not been found; however, some authors have suggested that serotonine, bradykinin and norepinephrine may play a role.[6,7]

Although the diagnosis of classical migraine offers no difficulty, atypical forms may be confused with autonomic epilepsy. In such a case electroencephalography will help. Rarely, vascular headache is due to conditions such as intracranial mass lesions, vascular malformations like aneurysm and arteriovenous fistulas, as well as functional disorders. Some patients with migraine headache have "migraine equivalents,"[8] consisting of (1) abdominal

pain associated with nausea, vomiting, and diarrhea ("Abdominal Migraine"), (2) pain localized in the thorax, pelvis, or extremities, (3) bouts of fever, (4) attacks of tachycardia, (5) benign paroxysmal vertigo, and (6) cyclical edema. Peptic ulcers may become active during a migraine attack, and asthmatic attacks and ulcerative colitis may alternate with migraine in some patients.

Within the "migraine family" there is a distinctive variety of headache called the "Cluster Headache." It is a unilateral headache with an abrupt onset and short duration that appears consistently on the same side and recurs often daily at about the same time each day for one or two months and then subsides to return after an interval of months or years. This type occurs in adults mainly. The prognosis of migraine headache in children is generally favorable.

Extracranial Problems

Extracranial conditions which cause cephalgia are usually easy to diagnose by a careful history and physical examination.

Ocular Disorders: Refractive errors are not a common cause of headaches in children. Infection of the eye and adnexa, trauma, and glaucoma will also cause headache.

Auricular Conditionss Acute infection of the ears usually causes localized pain. Otitis externa or otitis media may rarely cause pain referred to the head in older children.

Nasal Conditions: Rhinitis with the swelling of turbinate membranes produces pressure against the higher septal and lateral walls, and may cause headache; the pain may radiate into the neck, back, shoulders, and upper extremities as well.

Sinus Conditions: Acute sinusitis causes severe headache in children. Maxillary sinuses and ethmoid cells are present at birth, however, the frontal sinuses are not developed until six to ten years of age. Thus paranasal sinusitis may be seen in children, but not frontal sinusitis. Headache due to sinusitis can be over the eyes, frontal region, and paranasal area, while sphenoidal sinusitis causes pain in the suboccipital region, or sometimes across the bridge of the nose.

Dental Problems: Dental caries and periodontitis may rarely cause referred headache. Temporomandibular joint disturbances need to be considered.[6] Some patients develop malocclusion when missing molars are not replaced by adequate appliances. The symptom is temporal pain associated with otalgia which worsens while chewing. Habitual "grinding" of the teeth may also cause headache.

Functional Headache

Tension headache, the most common variety, is brought on by emotional conflict and/or muscle spasm of the cervical paraspinal muscles. Fatigue, weather changes, and menses are added factors in tension headaches. Many of these patients are adolescent females. The type and distribution of pain is not constant, but most patients have more than one attack per week. "Ferry's forehead sign,"[5] i.e., pointing to the area exactly between the eyebrows when asked to show the maximal area of discomfort is frequently present.

The duration and severity of a tension headache fluctuates with the stressful situation, such as school examination, or emotional problems with boyfriend or family. This headache does not interfere with the child's normal activities and recreation, in contrast to migraine headache. The child with migraine stops his normal activities and rests in a dark quiet room for several hours. Ergotamine does not relieve the pain of tension cephalgia which is another point in differentiation from vascular headache.

"Psychogenic Headache": Is seen in children without any detectable organic origin, who are recognized to have depression or conversion reaction after psychological evaluation. Headache in the young child may be seen as a symbol of communicating the anxiety of need deprivation.[7] If the child's demands are not met favorably, he unconsciously reacts with a headache. In younger children, lack of parents' love especially maternal affection, and

fears of loneliness may cause headache. "Monday morning headache" in a school-age child is a reaction to the anxiety of going to school. In conversion reaction, headache acts to decrease or prevent anxiety at the time of conflict. Psychoneurotic headache lasts for indefinite periods and fluctuates in relation to surrounding events; here the child can be distracted from his pain.

Allergic Headache

Recurrent headaches without any known etiology have long been attributed to an allergic state: various foods and inhalant allergens have been shown to cause seasonal, perennial, or paroxysmal headaches.[8] Migraine headache, which has been reported to be prevalent in atopic patients, has been considered to have an allergic origin by a number of authors.[9] It is believed that the antigen, either a food or an inhalant, combines with antibody and releases chemical mediators such as histamine, serotonin, kinins or Slow Reacting Substance of Anaphylaxis (SRS-A). These mediators cause constriction of smooth muscle, dilatation of microvessels, and stimulation of pain receptors. It has been shown that injection of bradykinin into migrainous patients will produce headache which is probably associated with cerebral vasodilatation.

In addition to antigen-antibody reaction, nonspecific etiological factors are involved. Overexertion, weather change, infection, and endocrinologic problems may trigger attacks of headache.

Allergic headache may be primary or secondary. Primary allergic headache, direct clinical symptom of allergic reaction on the central nervous system, may be frontal or typical migraine type, dull or throbbing, localized or diffuse. Patients with primary allergic headache may have a positive family history of allergy and/or a past history of an allergic disease. Exposure to offending allergens may cause an attack, while elimination of allergens may improve the headache.

Secondary allergic headache is a headache resulting from an allergic condition, most commonly allergic rhinitis. It is dull and frontal and is associated with a sensation of pressure in the paranasal regions. Such patients may have absolutely no nasal ventilation, while other symptoms include sneezing, dry mouth, snoring, and anosmia. When associated with perennial allergic rhinitis, the symptoms are chronic or semichronic. On examination, the nasal mucosa is pale and boggy; polyps may be seen.

The "pressure-referred" headache is also secondary to nasal allergy, with turbinate membrane swelling producing pressure against the upper septal and lateral walls. Pain may be noted in any part of the head, as well as in the neck, back, shoulders, and upper extremities.

Diagnostic Evaluation

A detailed personal and family history and careful physical examination is mandatory. History should be taken from the parents as well as from the child, if he is old enough to describe the pain. Parents may be able to describe the appearance of the child during the episode. The frequency and duration of headache, the intensity and progression of episodes, associated symptoms like nausea and vomiting, changes in mood, and loss of memory are all important. Headaches that occur during school period, especially repeating in one particular class, suggest a school problem. Late afternoon headaches in a school-age child is likely to be associated with an eye problem and refractive error. White flickering lights and scotomas before the episode suggest a migrainous type of headache. Often this type of patient gets relief by inducing vomiting. Headaches that are worse on rising in the morning, with gradual improvement during the day, will suggest a brain tumor, frequently located in the posterior fossa. Postictal headache may also be seen in patients with seizure during sleep, without parents noticing convulsions. In such a case, a history of bedwetting, and blood on the child's pillow due to tongue biting may help establish the diagnosis. A positive family history of seizure disorder or migraine will favor postictal headache or migraine headache, respectively.

A family history of allergy, and a history of exposure to a known allergen preceding an episode of headache should suggest an allergic headache, which is usually recurrent. Associated emotional disturbances should lead us to suspect psychogenic headache, which is chronic. The child may have periods of depression, and be unable to handle stressful situations. Sibling rivalry, school changes during the academic year, disturbed family relationships, separation of parents, or the working mother may be reasons for psychogenic headache.

Physical examination should be started by observation of the child's behavior and facial expression. One should look for any sign of depression, anxiety, or hostility. A child with severe headache has a facial expression consistent with the intensity of the pain. The physician should also observe the child-parents relationships. The growth chart, made by plotting the weight and height of the child may show linear growth disturbance if a pituitary tumor is present. Eye examination should include tests for visual acuity, and a fundoscopic examination to rule out papilledema, hemorrhage, or other abnormalities. Ears, nose, throat, and sinuses must be carefully examined as well as the blood pressure, heart, abdomen, femoral pulses, and neurological system. One must look for abdominal masses, enlargement of the kidneys, or heart disease, coarctation of the aorta, ataxia or other abnormalities of significance.

Diagnostic studies depend on the clinical impression, but should include a blood count, urinalysis and skull x-ray on all patients with headache. Electroencephalographic studies should be done in selected cases of migraine and other chronic headaches. Ventriculography, carotid angiography, and brain scan may be needed if one suspects an intracranial mass lesion. Sinus and mastoid x-rays may be needed. Although cerebrospinal fluid examination may be helpful in some cases, it is inadvisable in most children with headache. The potential hazards of temporal lobe or cerebellar tonsillar herniation in patients with increased intracranial pressure outweighs the benefit of lumbar puncture.

Consultation with an ophthalmologist or otolaryngologist, or neurologist may be indicated in some patients. A psychological evaluation should be made for those patients with emotional problems, after one rules out organic causes of headache. Although the history is more important in diagnosing an allergic headache, provocation with suspected allergens and skin tests may be helpful for the diagnosis of this headache.

Despite a careful diagnostic evaluation, there are some children whose etiology for headache remains unidentified.

Treatment

Treatment of children with headache depends on the etiology. Corrective lenses for refractive error, treatment of infection, psychotherapy, or alleviation of environmental factors may be specific.

Ergot preparation is administered for migraine. In some patients, phenobarbital relieves the pain; anticonvulsant drugs are prescribed for seizure disorders. Therapy for intracranial masses is not encouraging in children, as most of the tumors are not resectable. For allergic headache, the best treatment is elimination and avoidance of the offending food, inhalant or allergen.

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

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Sigmoidorectal intussusception with prolapse can occur with or without an associated mass lesion. This interesting case illustrates the diagnosis and treatment of such a situation caused by a lipoma which originated in the sigmoid colon.

Intussuscepting Lipoma With Prolapse Through The Rectum

Sidney Schultz, M.D. and
Philip Cheung, M.D./Long Branch*

Intussusceptions associated with mass lesions, as well as those without demonstrable associated lesions, may prolapse through the rectum. Sometimes the presenting situation may prove confusing to the clinician on physical examination as well as on sigmoidoscopy. The following is a case report of a lipoma which originated in the proximal sigmoid, produced intussusception, and prolapsed through the rectum.

Case Report:

A 79-year-old woman, was admitted because of a prolapsed rectal mass which appeared after a bowel movement. Physical examination revealed a large, bulbous mass protuding through the rectum. The mass was replaced into the rectum under anesthesia in the operating room but did not reduce. Sigmoidoscopy permitted visualization of the bulging mass, but a normal bowel lumen proximal to the mass was not encountered. Plain x-ray films of the abdomen did not reveal free intraperitoneal air. Emergency barium enema under sedation was then performed and revealed intussusception in the rectosigmoid with a large mass lesion, probably a large lipoma (Figures 1A, 1B). This mass was reduced to the proximal sigmoid (Figure 2), but an edematous appearance was noted in a portion of the sigmoid after reduction of the mass (Figure 3). This was felt to be a residual effect of the reduced intussusception or possibly due to vascular compromise of the bowel.

Figure 1A—Frontal projection showing an oval lucency in the rectosigmoid representing the lipoma. Note evidence of intussusception in the colon just proximal to the lipoma.

Figure 1B—Lateral projection demonstrating the lipoma in the rectosigmoid.

While undergoing a bowel prep, prior to surgery, a routine chest x-ray revealed free intraperitoneal air. On questioning the patient, it was learned that she felt abdominal pain prior to the x-ray procedure. Exploratory laparotomy revealed a large soft mass in the

*This work is from the Department of Radiology, Monmouth Medical Center, Long Branch.

midportion of the sigmoid. There were two punched-out areas of full thickness necrosis due to vascular compromise of the bowel; one area overlay the palpable tumor and the other was just distal to it. The distal area had a hole through which fecal material was exuding, so exteriorization of the sigmoid colon was performed. This was followed two days later by resection of a lipoma of the sigmoid colon.

Figure 2—Lipoma reduced to the proximal sigmoid.

Figure 3—Postevacuation film demonstrating the lipoma in the proximal sigmoid with some edema in a portion of the sigmoid.

The pathological findings were a polypoid submucosal lipoma of the colon measuring 7.5 by 5.5 by 3.8 centimeters. The lipoma was on a short pedicle. There were two intestinal perforations with surrounding necrosis, ulceration, and peritonitis (Figure 4).

Figure 4—Pathological specimen demonstrating the lipoma as well as evidence of bowel perforation (white arrow).

Six weeks later the sigmoid colostomy was closed and the patient was discharged two weeks after that in satisfactory condition.

Discussion

Most cases of intussusception occur in children, but 5 percent appear in adults.[10] The vast majority of adult intussusceptions have an associated process such as benign or malignant tumor, Meckel's diverticulum, and so on. Intussusception can occur in either the small or large bowel. Although it is stated that adult intussusception is often limited to the small bowel,[5] one series found eighty-four instances of intussusception in the colon with seventy-six occurrences in the small bowel.[10] The same series found an incidence of malignancy of 54 percent in colonic intussusception with 24 percent of enteric intussusceptions associated with malignancy.

Rectal prolapse is felt to represent an intussusception.[9] In sigmoidorectal intussusception, the distal sigmoid and upper rectum prolapse into the rectal ampulla.[7] It may simulate a polypoid lesion of the rectum or it may present with profuse mucous diarrhea and bloody discharge like a villous adenoma.[7]

Sigmoidorectal intussusception must be a diagnostic consideration in a patient with a rectal mass. This condition has been treated with a rubber catheter with subsiding of the mass and negative follow-up proctosigmoidoscopy.[8] Conversely, occasionally an intussusception into the rectum has been reduced by barium enema with no mass lesion identified and on repeat barium enema a lesion has been demonstrated.[4]

Lipomas of the colon occasionally produce intussusception or bleeding, but they are often silent clinically. They are the most common, benign, nonepithelioid tumor of the colon and rectum.[2] Lipomas are the most common benign tumors of the colon after adenoma.[11] They occur in women more commonly than men,[1,2] and two-thirds of the patients are sixty years of age or older.[2] They are more common in the proximal colon than in the distal colon, are usually submucosal in location, and may be multiple.[2] They can be an incidental finding at surgery or can present by prolapsing through the rectum.[11] The lesions usually appear yellowish in color because of the underlying fat. Ulcerative disease of the colon proximal to a lipoma has been reported.[6]

Among lesions other than lipoma causing intussusception and rectal prolapse, one may find adenocarcinoma.[3] Thus, it can be seen that sigmoidorectal intussusception can occur both with and without associated mass lesions and the differentiation may occasionally be difficult on clinical grounds. Prolapse of bowel through the rectum can also serve to complicate the issue. Careful barium enema examination can serve two purposes. It can reduce the intussusception so that surgery, if required, can be done electively after bowel preparation. It can also help determine if the intussusception is being produced by a mass lesion.

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ADVERSE REACTIONS: Withdraw glutethimide if a generalized skin rash occurs. Rash usually clears spontaneously within a few days after withdrawal. Occasionally, a purpuric or urticarial rash may occur; exfoliative dermatitis has been reported rarely. With recommended doses, there have been rare reports of nausea, hangover, paradoxical excitation, and blurring of vision. Rarely, acute hypersensitivity reactions, porphyria, and blood dyscrasias (thrombocytopenic purpura, aplastic anemia, leukopenia) have been reported.

DOSAGE: To avoid overdosage, individualize dosage. Not recommended for children under 12.
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Although tuberculosis mortality and morbidity rates have declined rapidly in the United States, this disease remains closely associated with deleterious health and welfare conditions present in most American cities. This paper reviews tuberculosis trends, giving major attention to urban New Jersey counties and municipalities with emphasis on the Newark problem.

Tuberculosis Trends in New Jersey

Mark A. Quinones, Ph.D
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Ann A. Browder, M.D./Newark

The decline in tuberculosis mortality and morbidity during the last three decades has occurred with such rapidity that many Americans view it as a disease of past generations. Yet, despite this dramatic decline, high rates of active tuberculosis still continue to be correlated with deleterious health and welfare conditions, i.e., the adverse social and economic factors of daily living such as poor housing, inadequate nutrition, crowding, high rates of alcoholism and drug abuse, and so on.

Unfortunately, all these factors are present in most American cities. It is equally important to understand cultural and ethnic factors, as well as the life styles of those afflicted with this disease in order that effective prevention, early case finding, and treatment programs can be instituted.

The National Scene: An Overview

Morbidity—In the United States, new active case rates continue to show a decline from a rate of 23.1 per 100,000 in 1967 to a rate of 15.8 in 1972. When age is considered, the greatest decline over a ten-year span (1960-1970) is most significant in the group 15-24 years where the decline for the period is better than 50 percent. The age groups 25-44, 45-64, and 65 and over also show greater proportional declines than the under 5 and 5-14 year age groups. Nonetheless, when all age groups are considered for the ten-year period, there is a decline from 30.8 per 100,000 in 1960 to 18.3 in 1970.

Highlights of tuberculosis morbidity data in the United States in the 1970's are

1. Over 50 percent of new active cases occurred among persons 45 years and older.

2. Males accounted for two-thirds of all new cases.

3. Blacks had a case rate of more than 4 times that of whites.

4. Centers with a population of 250,000 or more accounted for 40 percent of all new cases and 22 percent of the total population.

5. Low-income groups comprised 25 percent of the urban population, but more than 50 percent of the tuberculosis cases. The bulk of the tuberculosis problem in the United States tends to be concentrated in the eastern seaboard and other major cities throughout the nation.[1]

Mortality—Mortality from tuberculosis throughout the world has declined profoundly. The decrease in death rates since the end of World War II reflects not only higher living standards and better housing, but better medical facilities, early case finding, and the extensive use of chemotherapeutic agents which were introduced in the late 1940's and early 1950's. As a consequence, the tuberculosis death rate dropped some 90 percent (to 2.1 per 100,000 in 1971) in the United States

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[1]*Tuberculosis Facts in the United States.* National Lung Association Planning Office, April 1972.

and other highly industrialized centers of the world.[2]

The age standardized death rate from tuberculosis in the United States in 1967 was 3.7 per 100,000 among white males and 1.2 per 100,000 among white females. The corresponding figures for non-whites were 15.5 and 5.6 respectively. The death rates in the United States from 1967 to 1971 represent a gradual decline from 6,901 deaths (rate of 3.5 per 100,000) in 1967 to 4,380 deaths for a rate of 2.1 for 1971.

The decline in tuberculosis morbidity has not been as substantial as the decline in tuberculosis mortality. For example, in the United States the incidence rate of reported new active tuberculosis cases decreased from 53.0 per 100,000 in 1953 to 18.3 in 1970, a reduction of two-thirds. Tuberculosis deaths, on the other hand, declined by four-fifths for the same period. In the United States during 1970, there were 37,000 new cases of tuberculosis reported and 5,600 *deaths* from tuberculosis.

The New Jersey Tuberculosis Problem

The declining trend in new active case rates for New Jersey seems to parallel that of the United States showing a decline in active rates from 26.4 per 100,000 in 1964 to a rate of 16.4 in 1972. Of interest is the fact that for the State as a whole, the active case rate declined almost 40 percent for the period 1964-1972.

A review of the tuberculosis picture in the 21 counties in New Jersey during 1972 shows that those counties with large urban centers tend to have the worst tuberculosis problem. The five leaders in numbers of newly reported active cases are Essex, Hudson, Passaic, Mercer, and Union counties. When new cases are considered for the same period for selected municipalities, the data show that the eight municipalities with the greatest number of cases are mostly located in the northern counties: Newark (Essex), Jersey City (Hudson), Paterson (Passaic), Trenton (Mercer), Elizabeth (Union), East Orange (Essex), Camden City (Camden) and Atlantic City (Atlantic). (See Table I).

Table I

Newly Reported Active Cases by Clinical Status Select Counties and Municipalities New Jersey, 1972

Selected Counties	*Active Pulmonary*	*Non-Pulmonary*	*Total Active Cases*	*Case Rate Per 100,000*
Essex	310	31	341	36.3
Hudson	133	7	140	22.8
Mercer	75	12	87	27.6
Passaic	105	14	119	25.4
Union	76	7	83	15.1
New Jersey	1,103*	108	1,211	16.4
*Selected Cities***				
Atlantic City	24	1	25	52.9
Camden	23	6	29	27.8
East Orange	31	—	31	40.9
Elizabeth	30	1	31	27.3
Jersey City	95	5	100	38.3
Newark	233	24	257	66.7
Paterson	75	11	86	58.5
Trenton	47	3	50	46.9

*Includes 56 cases of pleurisy

**Over 45,000 population

Source: Annual Report for 1972, Prepared June 1973, New Jersey State Department of Health, Tuberculosis Services

A comparison of rank order of the 9 major municipalities in New Jersey for 1965 and 1969 shows some of the changes which have taken place within the State (Table II). Over this period (1965-69) Newark and Atlantic

Table II

Rank Order of Major New Jersey Municipalities for Cases and Case Rates, 1965 and 1969

1965 Rank	*Municipality*	*No. Active TB Cases*	*Rate Per 100,000 Population*
1	Atlantic City	56	91.0
2	NEWARK	336	84.5
3	Trenton	68	62.0
4	Hoboken	28	59.6
5	Jersey City	149	55.1
6	Paterson	78	52.9
7	Passaic	24	42.6
8	Camden	43	37.3
9	Elizabeth	43	36.7
1969			
1	NEWARK	278	69.2
2	Atlantic City	33	52.2
3	Paterson	73	48.6
4	Camden	45	38.0
5	Jersey City	94	34.7
6	Trenton	32	31.4
7	Hoboken	12	26.0
8	Elizabeth	30	25.2
9	Passaic	11	19.0

Source: New Jersey Lung Association, 1970

[2]*Ibid.*

City changed rank order, with Newark ascending to first and Atlantic City descending to second place in 1969. Jersey City has held the 5th position in both instances. Despite rank order changes, the nine municipalities accounted for 50 percent of all active tuberculosis case rates during the two periods under consideration.

A comparison of active tuberculosis cases by age groups per 100,000 population for 1963, 1967 and 1972 (Table III) reflects a number

Table III

New Active Tuberculosis Cases and Percent by Age in New Jersey 1963, 1967 and 1972

	1963		*1967*		*1972*	
Age Group	*No.*	*Percent*	*No.*	*Percent*	*No.*	*Percent*
All Ages	1,634	100.0	1,455	100.0	1,208	100.0
Under 5	82	5.0	99	6.8	59	4.9
5-14	58	3.4	83	5.7	52	4.3
15-24	153	9.9	135	9.3	116	9.6
25-44	567	35.1	466	32.0	413	34.2
45-64	498	30.4	455	31.3	394	32.6
65+	266	16.2	213	14.6	174	14.4
Not stated		-	4	0.3		

Source: 1963, 1967 data, New Jersey Lung Association 1972 data, 1972 *Tuberculosis Statistics: States and Cities,* June 1973 Issue, U.S. Department of Health, Education and Welfare, P.H.S.

of interesting trends. The age groups under age 5 and ages 5-14 showed a modest numerical increase in 1967, but a significant decrease in 1972, whereas all age groups above 14 years for the years 1967 and 1972 showed decreases over the 1963 figures.

When cities in the United States with a population of 250,000 or more are considered on the basis of new active cases, Newark ranked second and Jersey City sixteenth in 1967 with respective rates of 74.3 and 42.5 per 100,000 population. By 1972 Newark held first place with a rate of 69.6 while Jersey City moved up to the thirteenth position with a rate of 36.4 per 100,000.

Newark

In 1972 Newark ranked first in *new* active tuberculosis rates among major American cities with a population of 250,000 or greater (69.9 cases per 100,000), a position it has held for the past four years (see Table IV). Indeed

Table IV

*New active tuberculosis cases in cities of 250,000 or more population in the United States**

		1972	
City	*1971*	*Provisional No.*	*Case rate Per 100,000*
Newark	268	271	69.9
Honolulu	189	188	56.3
Baltimore	458	424	46.2
Richmond	106	118	46.2
Boston	299	285	45.2
Buffalo	144	202	44.9
Birmingham	134	120	40.8
El Paso	124	130	39.3
Jersey City	98	100	37.9
Chicago	1,385	1,256	37.6
Philadelphia	803	726	37.5
Cleveland	247	270	36.3
Houston	544	449	34.9
San Francisco	310	242	34.4
Dayton	64	80	33.4
Cincinnati	192	146	32.7
Atlanta	187	194	31.6
Detroit	620	477	31.5
Sacramento	85	81	31.0
Rochester	73	88	30.4
New York City	2,572	2,346	29.4
Indianapolis	191	218	27.0
Jacksonville	165	144	26.8
Tampa	77	74	25.9
San Antonio	196	171	25.5
St. Louis	239	155	25.4
Nashville	116	114	25.0
Austin	50	66	24.7

*Compiled from figures from American Lung Association Data

the tuberculosis problem in Newark has changed little during the past decade. During 1972 Newark recorded a total of 268 *new* active cases under treatment and 28 tuberculosis deaths.

Closer analysis shows that in the North and East Wards, during 1970, 39 percent of the live births were black. The black population in the South and Central Wards accounted for over 90 percent of the births whereas in the West Ward almost 75 percent of the newborn are black. The East Ward tuberculosis rate per 100 infant births is double the North Ward rate which in turn equals the rate of the West and Central Wards (the predominately "black wards"). This seems to rule out race as a factor when considering the tuberculosis rate for infant births in Newark.

During 1970 tuberculosis deaths were four times as great among blacks as among whites

(Table V); the national census at that time showed that 54 percent of the Newark population was black, so that the death rate was disproportionately high in that particular ethnic group.

Table V

Deaths from Tuberculosis, Newark 1970 by Ethnic Group

Ethnic Group	*Deaths*	*In thousands*	*Rate per 100,000 population*
White	4	168	2.4
Non-White	20	207	9.7

Source: Newark Health Department

During 1972, 28 Newark residents died of tuberculosis (20 males and 8 females). Interestingly, 10 of these were between the ages of 25-44 years (Table VI).

Table VI

Tuberculosis Deaths Newark City, 1972

	Total	*Male*	*Female*	*15-24*	*45-64*	*65+*
Tuberculosis of Respiratory System	22	15	7	1	9	5
Tuberculosis, Other forms	6	5	1		1	2

Source: Newark City case register 1972, Newark City Department of Health and Welfare

Discussion

Tuberculosis is one of the oldest diseases known to man. Despite vigorous attempts at control throughout much of the so-called "developed world," it still accounts for a significant number of deaths in those countries. Its presence in major American cities, Newark in particular, is a matter of serious concern to public health officials.

Much research needs to be done in order to answer critical questions for the control of the disease:

(a) Should BCG be used extensively as a prophylactic in areas such as Newark?

(b) Should repeated tuberculin testing of our young population take precedence over the use of BCG?

(c) Which drugs should be used prophylactically in exposed individuals or those with positive skin tests?

There is a danger that unless we address ourselves to these issues, we may develop a sense of complacency which could result in reversing the progress achieved to date.

In effect, in areas of high incidence rates we need to improve the present reporting system, case finding methods, and follow-up procedures. Effective screening programs directed at new migrant groups entering the city (who in many instances harbor the disease) must be established to find those with the disease in order to treat them before further spread occurs.

One vexing problem in the control of tuberculosis in an inner city is the frequent failure of patients to adhere to clinic appointments. The Newark clinic experience clearly concurs with this. Of equal importance is that contacts of those with confirmed disease often refuse to submit to testing and, where indicated, drug therapy. In such cases a focus on cultural factors may be crucial in order to achieve optimum care of the tuberculosis patient, his family and the community.

Clustering patterns of cases within the city must be examined thoroughly in order to focus screening and intervention activities. It is also important to attempt to elucidate the reasons for very high rates in certain geographic areas; it may well be that nutritional deficiencies or trace substance intoxication might increase susceptibility to or progression of tuberculosis in these areas.

100 Bergen Street

Convulsive shock treatment of depressive conditions seems to be more effective when seven or more treatments and a somewhat longer hospitalization are used.

Observations on Treatment of Depressions

Granville L. Jones, M.D./Summit*

In an effort to clarify and quantitate some of our impressions of the results of various modalities of treatment for depressions, we have studied 200 patients admitted to Fair Oaks Hospital for clinical conditions subsumed under the title "Affective Disorders" and other depressions. (Table I) The study period was January 1 to November 1, 1966, with a subsequent five-year follow-up period.

Table I
Populations Studied

Diagnoses	No. of Patients
Involutional (psychotic reaction, depressive reaction, or melancholia	88
Manic depressive (depressed or circular)	50
Psychoneurotic depressive reaction	43
Psychotic depressive reaction	15
Others (Chronic brain syndromes with depression; passive agressive personality with depression; psychophysiological reaction with depression; inadequate personality with depression)	4

Ages ranged from 17 to 80 years, with a median of 48.5; the peak of incidence was in the 50 to 59 year age group. Marital status was as follows: married 149; separated 3; divorced 7; widowed 22; never married 19. There were 141 females and 59 males, which shows a higher proportion of women than the general admission to Fair Oaks.

During the five-year follow-up period, we have a record of readmission of 62 patients to Fair Oaks or elsewhere; nine patients were listed twice in the 200 names. Some patients had as many as four readmissions, while some patients were admitted to more than one hospital. However, 51 patients came directly to Fair Oaks without going elsewhere, and nine patients were readmitted to other facilities for their first subsequent admission. We had no record of readmission in 138 cases. One patient died in the hospital; four were transferred directly to another institution; and 20 were discharged against medical advice.

Treatment Results

It is generally accepted today that the most effective treatment for prompt relief of a depressed state is convulsive shock therapy. In most instances this is combined with some type of psychotropic medication. Because of physical contraindications or the refusal of the patient or his family to permit shock treatment, some patients are treated with other modalities (Table II).

Table II
Treatment

Convulsive shock only	11
Convulsive shock with medication	149
Medication alone	31
Medication plus psychotherapy	2
Psychotherapy alone	1
Insulin	4
No treatment	2

There is no generally accepted "standard course" of shock treatments. However, it seems likely that we tend to undertreat rather than overtreat. Characteristically, there is quick disappearance of symptoms, so that the patient, his family, and sometimes the treating physician, conclude that there is no need to

*From Fair Oaks Hospital, Summit, New Jersey

continue treatment. We have observed a tendency to relapse, however, and believe that a few more treatments will, in some way, consolidate the gains.

Readmission

Results were reviewed with this in mind. Six shock treatments was arbitrarily chosen as the cut-off number; thirty-two patients received six treatments or less. One patient was transferred to another hospital, one died, and eight patients left the hospital against medical advice. Nine of the patients receiving six or less shocks (25 per cent) were subsequently readmitted.

For comparison, a second group of patients who received eight or more shock treatments was studied. There were 116 patients in this group. Of these, 23 patients (19 per cent) were readmitted. We also reviewed the eight patients who received seven shock treatments; four were readmitted, for 50 per cent. Although the groups are not large, we believe our hypothesis, that it is unwise to stop treatment before at least eight convulsive shock treatments are administered, is supported. Discontinuation of treatment may be brought about by such adverse factors as failure to develop a good patient-psychiatrist rapport, lack of family insight, or insufficient financial ability, which themselves may produce stress. In other words, factors which bring about a premature separation may be as significant as the number of treatments.

Among the patients who received other types of treatment, 31 were treated with drugs only. Three of this group were transferred, seven left against medical advice, and 10 patients were readmitted, for a 32 per cent readmission rate. The remaining included patients receiving only psychotherapy (1), drugs and psychotherapy (2), insulin and other drugs (4), and two patients who left before any treatment was instituted (2). This series is too small to develop any statistical conclusions, however, it is noteworthy that two patients who were treated with sub-coma insulin were readmitted. Improvement is difficult to quantify, however, we should note that 10 patients were described as "slightly" or "moderately" improved. Four of the patients left against medical advice, one patient was transferred to another hospital, and two patients were sent to nursing homes. It is interesting that only one patient with qualified improvement was a patient readmitted.

Of the 19 cases discharged as unimproved, 13 left against medical advice, and three were transferred to another hospital. Of the "unimproved" cases, four patients (21 per cent) were readmitted.

Length of Stay

Among 200 patients, 44 stayed longer than the average, 41 the average length of time, and 115 left in shorter than the average length of time. We allowed 5 per cent variation in judging the average stay. Of those staying less than the average length of time, 30 per cent were readmitted. Those staying approximately the average, surprisingly showed a 43 per cent readmission rate, and those staying more than the average length of time showed 20 per cent readmission. It again appears wise, when treating depressions, to carry hospitalization on for a time in order to consolidate the gains made in the early period.

It is difficult to explain the high return rate in those leaving at approximately the average length of time. Speculating, this might have to do with the fact that depressed patients are more vulnerable at the time when they have just entered into a remission. Discontinuation of treatment when the patient first enters into a period of remission is hazardous.

Summary

Two hundred consecutive admissions were reviewed after being out of the hospital for some five years. Of these, 160 received convulsive shock treatments, most of them combined with drugs. The patients receiving six or fewer shocks showed a higher return rate than those receiving eight or more. Adding the seven shock group into the minimum number, the difference is much more striking. The pa-

tients receiving medication only had a higher return rate. The influence of factors such as the length of stay in the hospital, rapport with patient and family, the possible stress of financial insecurity are discussed. We conclude that it is wiser to err on the side of over-treatment rather than under-treatment of depressions.

19 Prospect Street

Aralen Manufacturer Liable for Blindness in User

A pharmaceutical corporation was liable for blindness caused by damage to a patient's retina by a drug which it manufactured, a federal appellate court in Pennsylvania ruled.

The drug, Aralen, was prescribed in 1957 for a patient suffering from lupus erythematosus. He took the drug continuously until 1965, when a physician advised him to stop taking it. Beginning in 1965 the patient's vision worsened and by 1971 he was legally blind.

Aralen was first marketed in 1946 for the treatment of malaria. In 1955 the manufacturer issued a pamphlet which discussed Aralen treatment for lupus erythematosus. It also submitted such information for publication in PDR. Late in 1957, approval from the FDA was obtained to advertise and sell Aralen for use in rheumatoid arthritis and in lupus erythematosus.

Around 1957, medical literature appeared which implicated Aralen in permanent damage to the retina. Letters were received by the manufacturer from physicians who reported loss of vision, field changes, and retinal changes in patients treated with Aralen. In 1963, the manufacturer sent 248,000 letters to physicians warning of ocular complications and of the need for periodic ophthalmologic examinations of patients taking Aralen.

Claiming the manufacturer was negligent in failing to test the drug adequately before placing it on the market, the patient brought suit seeking damages for his permanent loss of vision. After a lengthy trial, the jury returned a verdict for the patient in the amount of $437,000. The manufacturer appealed, contending that the trial court erred in submitting to the jury the issue of whether it violated the FDA law and in charging the jury that it had a duty to warn both the treating and the prescribing physicians about the danger of retinal damage.

The appellate court first held that evidence indicated that the manufacturer had recommended Aralen for use in treating lupus erythematosus before it obtained approval from the FDA. Aralen was originally approved only for the treatment of malaria, the court said, and any change in use was obliged to have prior approval of the FDA. That issue was properly submitted to the jury, the court said.

Secondly, the issue of the adequacy of the manufacturer's testing of Aralen for use in lupus erythematosus was properly submitted to the jury. Although no long-term testing of Aralen was made until about 1963, letters from physicians reporting visual disturbances in their patients taking Aralen began in 1956. It was thus an issue for the jury as to whether the manufacturer had used appropriate foresight in testing Aralen.

The court next noted that the manufacturer was under a duty to warn patients of harmful effects of drugs. Most effective was a warning to the medical profession, both to prescribing and to treating physicians. Thus, the trial court's charge to the jury was proper.

The manufacturer's final contention on appeal was that the jury's award of $437,000 was excessive. The court said that the projected 6 per cent lifetime annual salary increase was speculation and ordered a new trial on the question of damages.

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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964

The role of the audiologist in detection of hearing impairment and the establishment of a definitive diagnosis is discussed. Outreach programs are needed in the inner city.

Identification of the Hearing Impaired: the Audiologist's Role*

Annette Zaner, Ph.D./Newark

The major burden of detection of hearing loss in young children currently rests first, with parents, and then with family physicians, pediatricians, or well-baby clinics, where the children are brought for other health related examinations. The audiologist is a relatively new addition to the health professions, whose participation has added a much-needed dimension to the detection process. The audiologist is that member of the professional "team" whose basic job it is to rule out (or rule in) a hearing loss in a potentially hearing handicapped child. Should a hearing loss exist, it is the audiologist's responsibility to obtain measurements of auditory sensitivity levels and other audiological data, as required, for an accurate determination of the nature and severity of the auditory deficit.

During the identification period, the audiologist's contribution to the deliberations surrounding the advisability of the use of amplification is a key one, and the audiologist frequently assumes sole responsibility for the hearing aid selection process and for the final determination of the most appropriate hearing aid. Then, during the identification period, the audiologist participates in yet another way. Perhaps, because of the unavailability, in our nation, of some universal system for early identification and management of hearing loss in children, perhaps because the audiology center is where the child and the parents mostly *are* and perhaps because his or her academic and clinical preparations encompass rehabilitative as well as diagnostic skills, the audiologist is frequently that member of the professional "team" who is called upon to coordinate the child's early identification program, often acting as liaison between and among pediatrician, otologist, parents, and—later—the school. This unique position necessitates the establishment of an ongoing, open communication system, between the audiologist and the other professionals involved, in order to provide the best professional program possible for hearing impaired children.

Early audiological assessment is essential in identification of hearing impairment. First, it is a crucial aspect of differential diagnosis, helping to distinguish between peripheral hearing loss and other factors that may be causative, in a delay in language acquisition and/or development. Second, in the presence of a potentially remediable loss of hearing, audiological assessment may provide the only available documented evidence necessary for medical intervention. Where medical management is instituted, audiological assessment is imperative, both for the establishment of base lines and for ongoing measurement of progress. Most important, however, early audiological assessment and identification is *the* key to the availability of appropriate education for children with a handicapping hearing loss. Much of formalized education is dependent upon the availability of a developed language system. Normal hearing children, for example, learn to read long after they have demonstrated the ability to function linguistically, and much of the material presented in schools

*Presented at the Annual Fall Meeting of the New Jersey Academy of Ophthalmology and Otolaryngology, November 14, 1973, Robert Treat Hotel, Newark.

is presented via the child's linguistic system. It has elsewhere been clearly demonstrated that language acquisition in normally hearing children is not something that suddenly occurs when the child is one and a half or two years old but, rather, it is a process that is dependent upon continual auditory linguistic input, from earliest infancy. Any prolonged delay or inadequacy in providing such input will invariably cause delayed and probably aberrant language development. The earlier a child with a handicapping hearing loss can be identified and provided with appropriate amplification, therefore, the greater is that child's chance for acquiring language that will be adequate for his or her educational needs. Recent information pertaining to the normal acquisition of language provides a clear mandate, then, for the identification of handicapping hearing loss as early in infancy as is possible, and the audiologist is clearly the professional particularly equipped with the skills necessary for such definitive assessment.

With a greater incidence of high risk births, with broader emphasis on earlier identification, and with more ready acceptance of the concept of including children in habilitative and rehabilitative programs at the age of identification rather than waiting until they are two, three or four years of age, audiology centers are now routinely called upon to provide differential diagnostic services for very young children. Considering the preschoolers who now constitute a sizable proportion of any diagnostic audiology caseload, it is hard to believe that only twenty to twenty-five years ago, engaging in pure tone audiometry with children under five was thought not feasible. Today, pure tone audiometry is routine with children aged *two*, and in some settings with far younger children. Nevertheless, audiological assessment of very young children — "behavioral audiometry" — does present the audiologist with some very real difficulties.

The requirements for testing hearing sensitivity are that the subject, regardless of age, respond to various auditory stimuli and, further, that the responses be reliably observable. More often than not, however, very young children are simply not yet capable of such attentive and deliberately responsive behavior. It is the responsibility of the audiologist, then, to find appropriate ways of eliciting the responses necessary for threshold determination. One approach is *play audiometry*, where the child is engaged in an activity with toys or games, designed to set up a specific response pattern to the various audible auditory stimuli. There are some young children, however, who—because of complex multiple organic involvement or because of nonorganic, emotional components—are difficult to test, even with play techniques. With increasing numbers of such children presenting a diagnostic challenge, audiology will further broaden its academic scope and enlarge its clinical repertoire to include greater information and more practice in early childhood development principles—especially, in the realm of problematic development and the various subsequent behavioral manifestations. The younger or more multiply involved the child, the greater the requirement of the audiologist to be knowledgeable about dealing with the child's behavior developmentally, during the audiological assessment process.

One of the more serious drawbacks to early audiological assessment, and therefore to early identification, is that the audiologist—because of the need to work in a sound controlled environment—has little potential mobility. Though hearing *screening* may be accomplished in makeshift or transportable, controlled acoustic environments, children requiring sound field or threshold hearing tests usually need to be referred to audiological centers, where standardized tests can be administered, with calibrated instrumentation, in an appropriate acoustic setting. Though this requirement may not pose a particular problem to families of middle or upper socioeconomic status, sad experience has shown that in large urban centers children from lower socio-economic status families, who are in need of audiological assessment are often not brought to the center—or are brought inconsistently—until they are perhaps of school age. "Identification" is thus delayed until it is

sometimes too late to hope that intervention will be of significant value for anywhere near normal language acquisition. One can speculate endlessly—and perhaps intelligently—about the reasons for the "no show" syndrome. If we mean to take seriously the mandate for early identification of hearing impairment, however, audiology needs to take its share of responsibility for developing and implementing innovative means for reaching children from the inner city as well as from the suburbs.

(Mt. Carmel Guild)
17 Mulberry Street

Recommended Immunization Schedule for Children*†

First seen in infancy		First seen at 1 to 5 years old		First seen at 6 or older	
Age	**Immunization**	**Age**	**Immunization**	**Age**	**Immunization**
2 months	DTP[1] TOPV[2]	First vist	DTP TOPV Tuberculin test[3]	First visit	Td TOPV Tuberculin test
4 months	DTP	1 month later	Measles, mumps, rubella (combined)	1 month later	Measles, mumps, rubella (combined)
6 months	DTP TOPV	2 months later	DTP TOPV	2 months later	Td TOPV
1 year	Measles, mumps, rubella (separately or combined)	4 months later	DTP TOPV	7 months later	Td TOPV
1½ years	DTP (booster) TOPV	6 to 12 months later or preschool	DTP TOPV		
4 to 6 years	DTP (booster) TOPV				
14 to 16 years, and every 10 years after	Td[4]	14 to 16 years, and every 10 years after	Td	14 to 16 years, and every 10 years after	Td

1. DTP = diphtheria and tetanus toxoids combined with pertussis vaccine.

2. TOPV = trivalent oral poliovirus vaccine. The recommendations are suitable for breastfed as well as bottle-fed babies.

3. Frequency of repeated tuberculin tests depends on risk of exposure of the child and on the prevalence of tuberculosis in the population group.

4. Td = combined tetanus and diphtheria toxoids (adult type) for those over 6 years of age, in contrast to diphtheria and tetanus (DT) containing a larger amount of diphtheria antigen.

*Recommended by the American Academy of Pediatrics, Committee on Infectious Diseases.
†Reprinted from *Consultant*, August 1974, p. 49

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Special Article

Bikini Atoll: A Footnote to History

Arthur Krosnick, M.D., Trenton

The U.S.S. Burleson, APA-67, was commissioned in the U.S. Navy on November 8, 1944 when Mrs. Darryl F. Zanuck, wife of the motion picture producer, splashed champagne across her bow. As an "attack transport" this vessel had extensive Pacific War Zone duty during World War II, including the invasion of Okinawa on April 1, 1945. The story of the "Mighty B," whose radio call was "Halfpint" and who earned a place in history, including medical history, may be interesting to physicians. Recently, a newspaper clipping restimulated many memories and provided a footnote to the story.

From April through early August, 1945, Admiral Halsey's Third Fleet engaged the Japanese along its coast until the first atomic bomb was dropped on Hiroshima on August 6, 1945, and the war ended dramatically. Following trips to Korea, Okinawa, the Philippines, Tientsin, Hong Kong-Kowloon, and Chinwangtao, China, which included encounters with two typhoons in the East China Sea, the Burleson was sent back to San Pedro, California in December, 1945.

Her new assignment proved to be most unexpected and was unusual, but "Halfpint" was equal to the task. The Burleson had been selected for conversion from an attack transport to a medical laboratory ship, in order to participate in atomic bomb tests to be held at Bikini Atoll in the Marshall Islands. "Conversion" meant literally stripping out the interior of troop and cargo spaces, offices, and other work rooms to install animal living quarters and laboratory facilities. The laboratory animals included mice, rats, guinea pigs, goats, and pigs. The research facilities were mainly planned for biochemical and hematological studies, gross, and microscopic pathology, and radiation studies. Among the scientists who boarded the Burleson, as a part of the research staff, were Captain Shields Warren and Commander John R. Tullis, pathologists.

An interesting sidelight to the conversion period might have been anticipated. The Burleson's Captain, at the time of the assignment to "Operation Crossroads," the first peacetime test of atomic weapons, was a Seventh Day Adventist by faith and an antivivisectionist. To his credit, this unusual skipper worked to develop comfortable quarters for the animals which were to be exposed to atomic explosions and sacrificed for scientific investigation. His strategic placement of antivivisection literature in the officer's wardroom, however, resulted in expressions of outrage from the scientists, who later accepted this gesture with amused tolerance. The Captain was spared the anguish of participating in the test when he was transferred to other duty before the newly furbished medical laboratory ship left California for her rendezvous with atomic energy at Bikini.

Bikini Atoll, a coral ring of more than 20 islands, was inhabited by 166 natives of mixed Melanesian-Polynesian stock. These islands, the largest of which was Bikini Island, covered a land area of only two square miles. With condemnation of their land, the Bikinians and their belongings were moved to Rongerik Island, 130 miles east of Bikini, where the U.S. Navy Seabees built a village for them.

The Burleson then carried her animal and scientific passengers to their destiny just north of the equator. "Operation Crossroads," which was planned to obtain precise data about the effects of atomic explosions on naval vessels and the ecology of the area, and to study radiation sickness, proceeded on schedule. After the targets (a total of 90 battleships, aircraft carriers, submarines, and landing craft) were anchored in the lagoon which stretched over 23 miles, thousands of instruments and animals were placed in the ships and on Bikini Island. On July 1, 1946, Test Able began at 34 seconds past 9 a.m.,

when an atomic bomb was dropped from an airplane and exploded in the air over the target ships. Test Baker, on July 25, 1946, was the first underwater atomic explosion of a bomb suspended in the water below LSM-60.

The scientists from the Burleson collected a great deal of material in their studies of the animals, some of which were killed outright by the heat and blast of the Able Day bomb. Other animals died later of radiation sickness, with shock, hemorrhage, anemia, and delayed infections due to leukopenia and loss of immune mechanisms. Half of the animals in the first test survived, but the underwater blast drenched and contaminated the ships with radioactive water, so that all the Test Baker pigs died by the end of two weeks.

In the meantime, the Bikinians were not able to adjust to Rongerik Island, due to the lack of natural resources for self-support, and the fact that Rongerik had less than one-half a square mile of dry land scattered over 17 tiny islands. Once again the islanders were moved by the Navy to the larger Ujelang Island, almost 300 miles from their native Bikini. It did not help the situation to be housed in tents, conjointly with American servicemen and foreign workers. However, it did not interfere with biological reproduction; by November, 1948 their population had increased to 184 when the final move to Killi Island (1.5 miles long, 0.75 miles wide, 0.36 square miles land area) was accomplished.

The latest chapter of this unhappy tale tells us that Bikini Island has been refurbished with 40 "model homes" built by the U.S. Government, and the exiles from atomic radiation have been urged to go back home. Not surprisingly, they are reluctant to go back for several reasons. In 1954, a very powerful nuclear device was exploded at Bikini with near disastrous results. An unexpected shift of wind direction seriously contaminated an area 240 miles long by 40 miles wide with radioactive fallout; 236 Marshall Islanders on Rongelap and Utirik Islands and 31 U.S. test personnel were exposed to the radiation. In addition, the 23-man crew of the Japanese fishing vessel "Fukuryu Maru," which had been 85 miles from the explosion, was exposed. The Marshall Islanders and U.S. personnel escaped with skin burns and temporary hair loss, but were unable to return to their homes for more than three years. The ship's crew, however, required hospitalization and treatment for radiation sickness for a year, and one ultimately died of "complications." Still later, in 1956, another test—the first hydrogen bomb dropped by a U.S. airplane—took place at Bikini.

Oceanographers studied Bikini's lagoon before and after Tests Able and Baker and collected monumental data on the ecology and geology of the atolls, and the effects of radiation on marine life. They demonstrated that radioactive elements were taken up by microscopic plant and animal plankton and entered the perpetual cycle of life at the atoll. Little fish ate the radioactive plankton, and in turn were eaten by bigger fish. Suppose the Japanese fishermen caught these fish, which were subsequently eaten by other human beings? A year after the original tests, some of the ships exposed on Baker Day were too radioactive for safety, and, according to Dr. Stafford L. Warren, then dean of the U.C.L.A. Medical School, and chief of radiological safety for the Army's Manhattan District, "they will remain contaminated for years." Dr. Warren predicted that "the contamination on Bikini could have no serious consequences because the atoll is isolated from human habitation and the fish were not the migratory kind which could spread radioactivity to other islands."

As a Burleson officer in charge of some aspects of its conversion in 1945, I had a small role to play. Having been discharged from the Navy to enter medical school, it was not my privilege to observe the atomic tests. However, as a physician today, I feel empathy for the Bikinian exiles whose mistreatment resembles the plight of the modern urban ghetto residents who are displaced to make room for a new office building project, only worse. Can one blame these unsophisticated and uneducated farmers and fishermen for refusing to return to Bikini? Can they trust the state-

ments of scientists made years earlier?

It is sad to know that yet another nation, India, has entered "the Atomic Club." Although the social scientists may be lagging behind the physical scientists, as physicians we cannot afford the luxury of being opinionless on such matters. Man's inhumanity to man has been a reality since he first stood erect. As humanists devoted to the "welfare of humanity," physicians individually and collectively should have and should express thoughts on projects which may disturb the environment temporarily or permanently, and which may produce morbidity and mortality among living creatures, including *homo sapiens*.

The Multiple Roads of Cancer Research

The outlook in cancer research has brightened considerably. In 1930 some 20 per cent of cancer victims survived; today the rate has risen to 33 per cent. Much progress has been made in the management of cancer of the colon, rectum, bladder, breast, uterus, and ovary. Prognosis for lung and stomach cancer remains poor.

Break-throughs in basic research have led to a better understanding of the causes of cancer. Recent discoveries strongly support the contention that some human cancers are caused by viruses. To date, viruses have been found in several forms of human cancer but scientists have been unable to determine whether any of these particles could cause cancer. "If this proves to be a true human virus," says Dr. Robert Huebner of the National Cancer Institute, "we'll be light-years ahead of where we've been."

Support for the virus theory also came from Albany. Hodgkin's disease has proved to be communicable to a small degree. Thirteen cases were discovered—and each of the victims had associated with at least one of the others or with a mutual acquaintance.

If diagnosed early, we can cure eight out of ten cases of Hodgkin's disease. The cancer is treated with radiation therapy or a new four-drug combination treatment developed at the National Cancer Institute. A new lead from two Boston researchers, Drs. Stanley Order and Samuel Hellman, could improve early detection of Hodgkin's disease. They believe that they have found a "tumor-associated antigen" which may signal Hodgkin's disease before symptoms develop. Cells of various types of tumors bear specific antigens that distinguish them from normal cells of other types of cancer.

This knowledge has been put to good use by Dr. Phil Gold of McGill University who isolated a specific antigen detectable in the blood for tumors of the bowel. The test has been run on 1,500 patients to detect cancer of the colon and rectum with 95 per cent accuracy.

Drs. Karl and Ingegerd Hellstrom of the University of Washington discovered that the blood of cancer patients contained "blocking" antibodies that prevent the body's protective white blood cells from destroying cancerous tumors. They are now studying "de-blocking" antibodies in the hope that they will neutralize the blockers and permit the patient's own white blood cells to destroy the cancerous cells in his body.

An entirely new kind of agent—the viroid—was discovered by a U.S. Department of Agriculture pathologist. Dr. Theodor Diener said that the viroid may prove to be responsible for diseases such as infectious hepatitis and some forms of cancer. The viroid is one-eightieth the size of the smallest known virus.

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NEW JERSEY DOCTORS' NOTEBOOK

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

The College of Medicine and Dentistry of New Jersey (CMDNJ) has been notified that its continuing medical education programs have been given provisional approval by the American Medical Association's Council on Medical Education. This accreditation, the result of a site visit by the Council's Advisory Committee on Continuing Medical Education in December, applies to all courses offered at CMDNJ — New Jersey Medical School in Newark, and at CMDNJ — Rutgers Medical School, Piscataway, for practicing physicians. A provisional approval is given to an institution that has a new program or a program in development, and the Council on Medical Education customarily resurveys the program after two years.

The courses, which are generated by various departments within the College, are, however, not CMDNJ's only contribution to continuing medical education in New Jersey. It is working hard to help professionals in practice. The rapid development of knowledge and technology—the information explosion—has made continuing medical and dental education a "must" to keep physicians and dentists abreast of advances or to permit them to acquire new skills in a planned, organized, and convenient manner.

As the primary source of professional health care education in New Jersey, CMDNJ has taken the initiative in helping to bring continuing education programs to the state's physicians and dentists. The work is centered in the Office of Continuing Medical Education (OCME), which is located at the CMDNJ — Rutgers Medical School Campus in Piscataway. Founded two years ago, the office, directed by James A. Rogers, M.D., has geared itself to help community hospitals throughout the state to organize their own departments of continuing education.

The community hospital is where the physician's problems arise and are solved, and where he devotes most of his time. By assessing their own needs, and utilizing their own talents, local hospitals are developing educational programs that are both relevant to the physician and convenient to him. The role of the community hospital in providing accessible continuing education to the professional has been underscored by recent trends in the profession. The issue of professional accountability has attained national importance, and CMDNJ's Office of Continuing Medical Education has judged its first job to be informing the State's hospital medical staffs of their increasing legal and professional responsibilities for the quality of medicine practiced in their hospitals.

As of July 1, 1976, the AMA Physicians' Recognition Award will become a requirement for maintaining membership in The Medical Society of New Jersey. The award is presented to physicians on completion of 150 hours of continuing education during three years, all or most of which should be in accredited programs. In order to make this requirement reasonable for New Jersey's physicians, it is important that adequate programs be accessible to practitioners. The authority to accredit continuing education programs within the state belongs to the Committee on Medical Education of The Medical Society of New Jersey. The Committee has completed accreditation of programs at 30 hospitals and 20 more are expected to be completed by the end of 1974.

Dr. Rogers, an internist who is currently President of The Medical Society of New Jersey, coordinates CMDNJ's programs with those of the Society. His office also works closely with the Academy of Medicine of New

Jersey, the educational arm of MSNJ and of many specialty groups. The academy also serves as a clearinghouse for information about medical education courses and seminars offered throughout the State.

One practical method of finding out what the physician needs is by auditing his performance, and OCME is offering its services, on a consulting basis, in a peer review project. The project, which initially includes 20 hospitals, is designed to help physicians to determine the norms for standard care at their hospitals. Since the norm for minimum care, even in uncomplicated cases is not a black and white issue, OCME works with physicians and surgeons to modify the norms to fit in with procedures at their particular hospital. Once norms have been established, it's easier to locate areas of educational need and to organize programs in response to these needs.

OCME also offers workshops in educational planning and lecture skills for hospitals developing continuing education programs. It is important to realize that the practicing physician is a very different type of student from the intern and resident to which hospitals have geared their past efforts in medical education. While a hospital may wish to administer its continuing education program through the same office as its residency program, it must develop learning activities that are appropriate and relevant to the practicing professional.

In conjunction with the New Jersey Hospital Association and the Academy of Medicine of New Jersey, CMDNJ's OCME recently sponsored a highly successful five-day training course for health record analysts. The program, conducted by the Commission on Professional and Hospital Activities of Ann Arbor, Michigan, is designed to fill the need for highly skilled people to analyze computerized data and to work with physicians in evaluating performance.

The main goal of Dr. Rogers' office is to pinpoint educational needs in the health care delivery system in New Jersey that have not been filled through traditional academic programs, and suggest the means for improving them. CMDNJ is working to provide appropriate advanced education in medicine and dentistry to serve the short-term needs of practitioners and the long-term needs of the professions.

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Communicable Disease Control Program of the New Jersey State Department of Health during August 1974:

	1974 August	1973 August
Aseptic meningitis	31	55
Primary encephalitis	3	4
Hepatitis: Total	293	194
Infectious	115	84
Serum	55	41
Unspecified	123	69
Meningococcal meningitis	2	5
Mumps	7	26
German measles	4	8
Measles	37	25
Salmonella	162	113
Shigella	73	61
Tuberculosis	82	
Syphilis	79	
Primary	37	
Secondary	42	
Gonorrhea	1,384	

Note: Gonorrhea, syphilis, and tuberculosis are figures for the previous month.

Shigella

The increasing occurrence of *Shigella sonnei* infections in recent years has resulted in epidemiologic investigations of outbreaks in urban areas. Shigella has higher attack rates for children under 10 years of age. Outbreaks can originate from a common source—from contaminated food or water—however, more commonly, shigellosis is spread by person-to-person transmission.

Settings in which children have close contact with one another for intervals of several hours

or days can be regarded as high-risk for exposure to any communicable disease, including shigellosis. Traditional settings for outbreaks of shigellosis have been institutions, boarding schools, and camps. The day-care center, a relatively recent type of child care environment, also meets the criteria of a high-risk setting for an outbreak of shigellosis. In addition, because children attending day-care centers return to different homes each evening, each infected child can expose and transmit the communicable disease to members of his family and neighborhood contacts outside the day care center. Thus it is not unusual to find a day-care center the focal point of a "community" outbreak of shigellosis.

An example of transmission of shigellosis from an urban day-care center into a community was investigated by the Communicable Disease Program in the spring of this year. The day-care center involved had an enrollment of 40 children and 18 employees. History revealed that 26 of these children and one employee had been symptomatic with fever, vomiting, diarrhea, and abdominal pain over a three-week period. Fourteen of these individuals had laboratory isolates of *Shigella sonnei* from their stools. In addition, 26 family and neighborhood contacts of these children and adults were symptomatic; 14 were laboratory confirmed cases. Isolates of shigella were obtained from 12 asymptomatic individuals. In general, the illness was mild, however, several of the youngest children involved were hospitalized for their illness.

Sporadic cases with the same antibiogram pattern occurred in the city over the following two months. About half of these could be traced to contact with children attending the original day-care center.

Surveillance and prompt institution of control measures for cases of communicable disease in children attending day-care centers will, hopefully, limit community spread of infectious diseases.

Therapeutic Drug Information Center

The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center of the New Jersey Regional Medical Program and the Brookdale Inter-regional Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, conjointly compile the information contained in this column each month. The New Jersey component is located at the Valley Hospital in Ridgewood. The Center serves as a source of intelligence on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions, and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor of Pharmacy and Director of Drug Information, Brooklyn College of Pharmacy, is Project Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College is pharmacologist consultant. The service is free, available Monday through Friday from 9 a.m. to 5 p.m.—telephone (201) 445-4900, extension 132. Following are questions and answers handled by the Center recently.

1. Do you have any information concerning adverse effects associated with long-term, low-dose tetracycline therapy in acne vulgaris?

Long-term, low-dose tetracycline therapy is widely used in the treatment of inflammatory acne lesions.[1,2] A typical regimen starts with tetracycline 250 mg, three times a day, and then the patient is maintained on 250 mg to 500 mg daily.[3] When elevated doses such as 1250 mg/day were used, side effects including nausea, vomiting, and diarrhea occurred. These side effects quickly subsided upon lowering the dosage.[4]

Kinn, Shalepa, and Baer[5] used 1.5 to 3 grams/day of tetracycline on 80 patients. After three months of treatment, the only side effect noted was phototoxic effects in two patients. Another study has shown that continued use of antibiotics leads to a higher rate of colonization of the anterior nares of acne patients by

gram-negative organisms. However, the concomitant use of hexachlorophene-containing soaps appeared to be a contributing factor.[6]

It is the general impression among clinicians that there is very little danger of any serious blood change occurring from long-term, low-dose tetracycline therapy. In a study that consisted of 55 patients (of which 22 completed the study), three test subjects showed a slight leukopenia, two showed a very slight degree of toxic granulations of leukocytes, and three instances of polymorphonuclear leukocyte-lymphocyte reversal (two were in the control group) were found. No test subject showed a low packed cell volume, and although 18 patients had their white blood cell count lowered, no count below 5000 was observed.[7]

Kestel[8] reported that two female patients who received 1000 mg/day of tetracycline chronically for several years developed what appeared to be tetracycline induced onycholysis in the absence of photosensitivity. This appears to suggest that on occasion onycholysis could occur either as part of the photosensitive reaction from tetracycline or independently.

A report appeared that a 16-year-old girl who received 250 mg of tetracycline twice a day for two and a half years developed a malignant lymphoepithelioma. As tetracycline has been reported to be immunosuppressive and teratogenic in laboratory animals, it might predispose toward malignant change when taken for a long period of time.[9]

Increased susceptibility to additional infection has received considerable attention. Bjornberg and Roupe[10] studied 51 acne patients on low dosage of tetracycline for more than six months (mean 16 months) and compared them (by means of a questionnaire) with 51 matched healthy controls as to their opinion of the occurrence of symptoms of some types of infection. There was no indication of an increased susceptibility to develop infections in the tetracycline treated group. In another series conducted by the same authors, 6 of 44 women on low-dose tetracycline had symptoms of monilial infection of the genitals.

In conclusion, to date, long-term, low-dose tetracycline HCl appears to be associated with few serious side effects.

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2. How effective is propoxyphene as a mild analgesic?

The therapeutic value of propoxyphene hydrochloride (Darvon®) and propoxyphene napsylate (Darvon-N®) remains equivocal. There is conflicting evidence in the literature regarding the effectiveness of propoxyphene, either alone or in combination.

Upon request of the FDA, Eli Lilly and Company issued a letter dated May 19, 1972, clarifying some facts about propoxyphene. The letter stated the following:

"There is no substantial evidence to demonstrate that 65 mg of Darvon® is more effective than 650 mg of aspirin (two 5-grain tablets), and the preponderance of evidence indicates that it may be somewhat less effective.

"The preponderance of evidence indicates that Darvon® is somewhat less potent than codeine. The best available evidence is that Darvon® is approximately two-thirds as potent as codeine. Furthermore, there is no substantial evidence that, when administered at equianalgesic doses, Darvon® produces a lower incidence of side-effects than codeine."

Miller and associates[1] extensively reviewed the literature and concluded that propoxyphene is no more effective than aspirin or codeine and may be inferior.

Beaver[2] concluded that propoxyphene hydrochloride (65 mg) is superior to a placebo but doses of less than 65 mg are of questionable efficacy. He estimated the potency of propoxyphene to be one-half to one-third that of codeine and believed that propoxyphene hydrochloride (32 mg to 65 mg) is no more and possibly less effective than the usually used dose of aspirin.

Hopkinson[3] compared the analgesic effect of 650 ml of acetominophen with 65 mg of propoxyphene, and with a placebo. He found no difference between the analgesic effect of propoxyphene and the placebo.

A recent double-blind study by Moertel, *et al.*[4] compared analgesic drugs in 100 patients with pain due to cancer. Propoxyphene hydrochloride alone showed a slight but *insignificant* advantage over placebo and was inferior to aspirin. A combination of 100 mg propoxyphene napsylate with 650 mg aspirin showed no statistically significant difference in analgesic effect than 650 mg of aspirin and consistantly ranked lower than the combination of 65 mg of codeine and 650 mg aspirin.

In conclusion, it appears that propoxyphene and its combinations may be over prescribed when one considers their analgesic effectiveness.

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3. Does minocycline (Minocin®) have a broader range of activity than other tetracyclines?

The *in vitro* activity of minocycline appears to be greater against *Staphylococcus aureus* than the other tetracyclines.* Against other bacterial species, superiority of minocycline is less evident or nonexistent.

Fedorko and co-workers[1] compared the *in vitro* activity of minocycline to that of tetracycline, oxytetracycline, chlortetracycline, and demeclocycline. Minocycline was the most active against *Staphylococcus aureus.* (Eighty percent of tetracycline-resistant staphylococcus tested were sensitive to minocycline).

Kuck, *et al.*[2] reported that minocycline was more active *in vitro* than doxycycline, demeclocycline, methacycline, and tetracycline against 101 clinical staphylococcal isolates.

Nelson[3] and Landes[4] reported that patients with tetracycline-resistant staphylococcal infections showed clinical improvement after a course of therapy with minocycline. Leigh and Simmons[5] reported that of the isolates tested, minocycline would have been effective against *Staphylococcus aureus* reported resistant to tetracycline.

In conclusion, minocycline has been shown to be more active *in vitro* against certain strains of *Staphylococcus aureus* than other tetracyclines. However, tetracyclines are not the drugs of choice for staphylococcal infections. Penicillin G is the drug of choice for nonpenicillinase producing species; a penicillinase-resistant penicillin for penicillinase producing species.[6]

*Tetracycline drugs include: tetracycline (Achromycin,® etc.); chlortetracycline (Aureomycin®); oxytetracycline (Terramycin®); doxycycline (Vibramycin®); demclocycline (Declomycin®); methacycline (Rondomycin®)

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Columbia University Cites Dr. Saffron

The Archivist-Historian of The Medical Society of New Jersey, Morris H. Saffron, M.D., was honored at Columbia University's most recent commencement by being named recipient of the Presidential Citation for distinction in his services to Columbia University and to the libraries. Dr. Saffron, a practicing dermatologist in New York and in Passaic, who was awarded a Ph.D. by Columbia in 1968 for his dissertation on the life and works of a medieval physician, Maurus of Salerno, (d. 1214), was cited for "his contributions to the academic world as an authority in the field of the history of medicine." Recognition was also given to his tenure as chairman of the Council of the Friends of the Libraries, a post he held from 1967 to 1972, and for his own gifts to the libraries and the encouragement of gifts by others, including the manuscripts of John Jay, the nation's first chief justice, by Dr. Saffron's college class.

An authority on American colonial medicine, Dr. Saffron lectures on the history of medicine at CMDNJ and is author of a biography of Samuel Clossy, the first professor of anatomy at King's College Medical School (Columbia University's College of Physicians and Surgeons). He was chairman of the Academy of Medicine's first Section on Historical and Cultural Medicine, and is honorary curator of the Library of Science and Medicine at Rutgers and a trustee of the New Jersey Historical Society.

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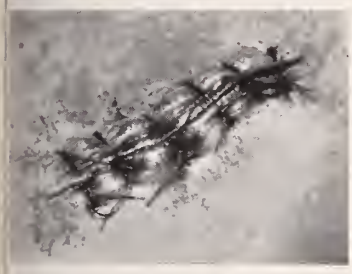

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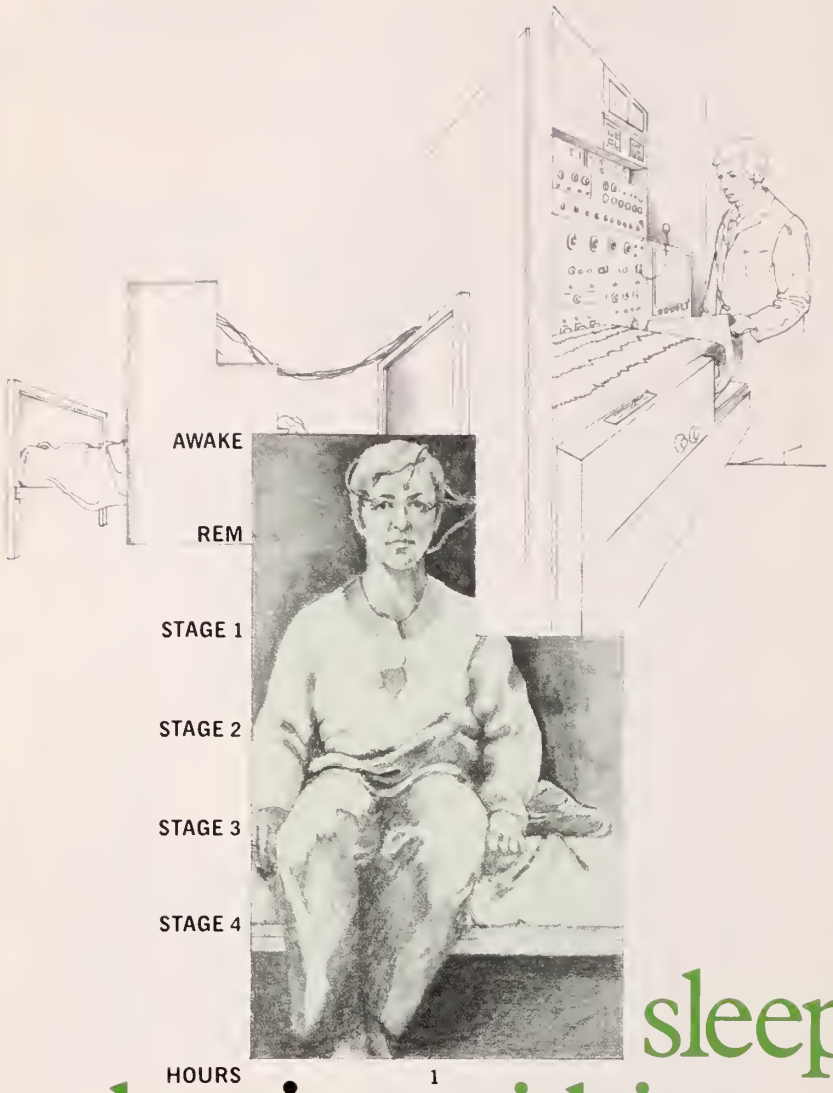

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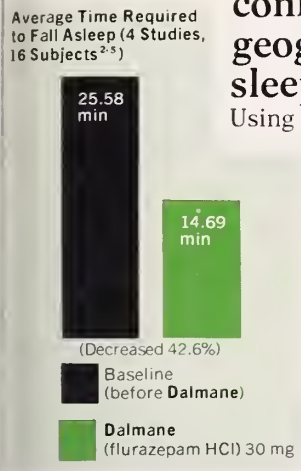
proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

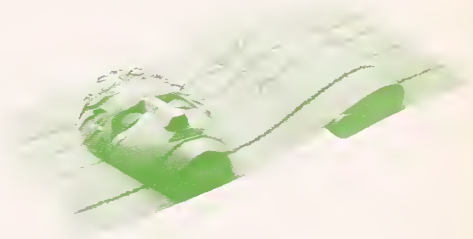
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, descreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles and Single Unit Packages of 100 capsules.

SK&F CO.
Carolina, P.R. 00630
Subsidiary of
SmithKline Corporation

KEEP THE HYPERTENSIVE PATIENT ON THERAPY
KEEP THERAPY SIMPLE WITH
DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

No potassium supplements
No special K^+ rich diets
Just 'Dyazide' once daily or twice daily

Studies have demonstrated that two prime reasons patients drop out of hypertensive therapy are: (1) the patient failed to understand directions, and (2) the regimen was overly complicated.* Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

*E.D. Freis: The Modern Management of Hypertension, V.A. Information Bulletin, 11-35.

TO KEEP BLOOD PRESSURE DOWN AND KEEP POTASSIUM LEVELS UP

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

EMERGENCY ROOM—Jeffrey S. Menkes, M.D., 41 Morris Road, West Orange 07052. Yale 1972. Hospital or group. Available September 1974.

GENERAL PRACTICE—Young S. Kim, M.D., 420 Stockholm Street, Apt. B-10, Brooklyn, New York 11237. Yonsei (Korea) 1964. Board eligible in internal medicine. Solo partnership, or group. Available January 1975.

INTERNAL MEDICINE—Joseph G. Boak, M.D., 1455 Jericho Rd., Abington, Pennsylvania 19001. Univ. of Pennsylvania 1970. Board certified. Subspecialty cardiology. Group. Available.

Thomas J. Cuomo, Jr., M.D. 5405 Markview Lane, Richmond, Virginia 23234. Jefferson 1968. Board eligible. Subspecialty, cardiology. Group or partnership. Available June 1975.

Harry Seneca, M.D., 420 Park Place, Fort Lee 07024. Tulane 1943. Board certified. Subspecialty, gastroenterology, immunology. Group or partnership. Available.

Stephen Glouberman, M.D., 1403-A Washington Blvd., San Francisco 94129. SUNY (Downstate) 1966. Board eligible. Subspecialty, gastroenterology. Group or partnership. Available January 1975.

Manjit Singh, M.D., 1874 Pelham Parkway, South, Bronx, New York 10461. New Delhi 1966. Group or partnership. Available.

Syed A. Qaiyam Jafri, M.D., 390 1st Avenue, Apt. 11-H, New York 10010. Liaquat (Pakistan) 1965. Board certified. Subspecialty, cardiology. Group, solo, hospital, teaching. Available December 1974.

Vincent T. Randazzo, M.D., 3719 Sebille Drive, Alexandria, Louisiana 71301. Jefferson 1973. Board certified. Group, partnership, or hospital. Available August 1975.

Yen-Jen Fuh, M.D., University Hospital, University of Kentucky, Lexington, Kentucky 40506. National Taiwan University 1963. Board certified. Group or partnership. Available.

John V. Mendola, M.D., 289 Kerrigan Boulevard, Newark 07106. Hahnemann 1972. Board eligible. Small group, partnership, or solo. Available June 1975.

P. Govindarajan, M.D., 12000 Fairhill Road, Apt. 502, Cleveland, Ohio 44120. Madras University (India) 1966. Board eligible. Subspecialty, gastroenterology. Group partnership, hospital, or solo. Available July 1975.

Joonhi Choi, M.D., 636 Brooklyn Ave., Apt. 8-H, Brooklyn, New York 11203. Seoul National University (Korea) 1964. Board certified. Subspecialty, hematology. Solo, group, or association. Available.

NEUROLOGY—Sang Jin Yoo, M.D., 4470 Granada Boulevard, Apt. 7, Warrensville Heights, Ohio 44128. Yonsei (Korea) 1969. Group or solo. Available January 1975.

OBSTETRICS AND GYNECOLOGY—Richard Fox, M.D., 200 Carman Ave., Apt. 19-B, East Meadow, New York 11554. St. Louis 1970. Association or partnership. Available July 1975.

Whan Soon Chung, M.D., 104 Sundridge Dr., North Tonawanda, New York 14120. Yonsei (Korea) 1966. Board eligible. Solo, group, partnership. Available January 1975.

Hugo Cimber, M.D., Tower Mountain Drive, Bernardsville 07924. Zurich (Switzerland) 1954. Board certified. Group, partnership, or hospital. Available.

Anant R. Bhati, M.D., 506 Dixmyth Avenue, Cincinnati, Ohio 45220. S.M.S. Medical College, Jaipur (India) 1964. Board eligible. Group, partnership, or solo. Available August 1974.

OTOLARYNGOLOGY—Nae H. Park, M.D., 515 West 59th Street, Apt. 5-N, New York 10019. Kyung Pook (Korea) 1966. Board eligible. Solo, partnership, group. Available July 1, 1975.

Nabeel M. El Romman, M.D., 921 St. Ann Place, Richmond, Virginia 23225. Cairo University 1968. Partnership or solo. Available July 1975.

PATHOLOGY—Satish C. Shah, M.D., 229-26 Kingsbury Avenue, Flushing, New York 11366. B.I. Medical (India) 1964. Board eligible. Solo, institution, group, or partnership. Available.

PEDIATRICS—Jerry J. Ferlauto, M.D., 2210 Auburn St., Rockford, Illinois 61103. Bologna (Italy) 1971. Board eligible. Subspecialty, neonatology. Group, partnership, or hospital. Available January 1975.

Barton W. Kaplan, M.D., 4358 Millwood Circle, Liverpool, New York 13088. SUNY (Upstate) 1968. Board eligible. Group or association. Available June 1975.

John A. Niziol. M.D., 5831 Walnut Street, Apt. 2, Pittsburgh 15232. Maryland 1972. Board eligible, Group or partnership. Available June 1975.

Joseph A. Hesch, M.D., Box 62, Avalon, New Jersey 08202. Jefferson 1934. Board certified. Part or full-time, salaried, clinical or executive. Available March 1975.

Arnold Kramer, M.D., 445 Edgemont Avenue, Palmerton, Pa. 18071. Duke 1962. Board certified. Association. Available.

Isaac G. Doron, M.D. Stevens Clinic Hospital Apts., Welch, West Virginia 24801. Cairo University (Egypt) 1953. Board eligible. Group or partnership. Available.

SURGERY—Enrique A. Saenz, M.D., McDonald Army Hospital, Fort Eustis, Virginia 23604. Javeriana (Bogota, Colombia) 1962. Group or partnership. Available January 1975.

Wuk Kim. M.D., 900 Woodward Avenue, Pontiac, Michigan 48053. Pusan (Korea) 1966. Board eligible. Partnership (would include general practice). Available July 1975.

Peter Salzer, M.D., 200 Carman Avenue, Apt. 13-A, East Meadow, New York 11554. Tufts 1970. Group. Available July 1, 1975.

Emil Von Arx, M.D., 55 Culberson Road, Basking Ridge 07920. Boston University 1967. Board eligible. Group or partnership. Available.

UROLOGY— Harinath Kumar, M.D., 26 Meadow St., Demarest 07627. Gandhi (India) 1963. Group, partnership, or solo. Available.

Roger Wolfert, M.D., 101-B Birch Circle, Elgin AFB, Florida 325-42. SUNY (Downstate) 1968. Partnership or group. Available July 1975.

J. M. DeCento, M.D., Woodbine Road, Shelburne, Vermont 05482. Vermont 1973. Association. Available July 1975.

CLINICAL NOTES

Diodoquin(R) (Diiodohydroxyquin) Toxicity (Blindness) in Children

Miles E. Drake, M.D. and Miles E. Drake, Jr.
Vineland*

The original observations of Cohlan[1] in 1956, that Diodoquin® was extremely effective in chronic non-specific diarrhea has led to its use in celiac disease, starch intolerance, intestinal allergy, intestinal intolerance, malabsorption syndrome, acrodermatitis enteropathica and other undetermined causes of non-specific diarrhea in infants and children. A close relative of Diodoquin,® namely Vioform® (iodochlorhydroxyquin), was implicated in a wide-spread epidemic of a syndrome of subacute myelo-optic neuropathy in Japan in the early seventies. The epidemic syndrome subsided promptly following the withdrawal of this drug from the market.[2]

There have been three cases of optic neuritis and blindness reported following the use of Diodoquin®[3,4,5] and now two more cases of blindness reported[6,7] following the use of Diodoquin.® Recently pathological findings in the jejunum and skin have resulted from the use of Diodoquin.®[8]

One of the authors recently saw a nine-month-old infant from another state who had been on Diodoquin® for non-specific diarrhea for two months. Examination showed the retina and optic nerves to be normal. The Diodoquin® was discontinued.

This clinical note is to alert all physicians that Diodoquin® is a potentially dangerous and toxic drug in infants and children and we feel should not be used except in acrodermatitis enteropathica and the carrier state (asymptomatic cyst passers) of amebiasis. Even here it must be used with extreme caution and only where unequivocally indicated. If one uses Diodoquin,® and it is clearly indicated, he must be aware of the potential toxicity and be so forewarned. The patient should be kept under close observation and be seen regularly by an ophthalmologist to assess visual function and include estimation of visual fields. The ophthalmologist must also watch for early signs of retinal arteriolar narrowing or pigmentary irregularity. The discontinuation of the drug is a must with the first signs of visual dysfunction since the damage to the retina may not be reversible.

It can be categorically stated that Diodoquin® should not be used for non-specific diarrhea in infants and children, under any circumstances. The failure to recognize and to be

*This study is from the Department of Pediatrics, Newcomb Hospital, Vineland. Mr. Drake, Jr., is a medical student at Duke University Medical School.

cognizant of the possible severe optic neuritis caused by Diodoquin® may lead to legal complication of a major proportion.

References

1. Cohlan SQ: Chronic nonspecific diarrhea in infants and children treated with diiodohydroxyquinone. *Ped* 18:424, 1956

2. Oakley GP: The neurotoxicity of halogenated hydroxyquinolines. *JAMA* 225:395, 1973

3. Etheridge JE and Stewart GT: Treating acrodermatitis enteropathica. *Lancet* 1:266, 1966

4. Berggren L and Hansson O: Treating acrodermatitis enteropathica. *Lancet* 2:566, 1973

5. Pittman FE and Westphal MC: SMON and inflammation of the colon. *Lancet* 2:566, 1973

6. Pittman FE and Westphal MG: Optic atrophy following treatment with diiodohydroxyquin. *Ped* 54:81, 1974

7. Fleisher, David L *et al:* Blindness during diiodohydroxyquin (Diodoquin®) therapy. A case report. *Ped* 54:106, 1974

8. Rayhanzadeh S and Dantzig P: Acrodermatitis enteropathica with pathological findings in jejunum and skin. *Ped* 54:77, 1974

Unique Treatment of an Impacted Foreign Body

Jack Grundfest, M.D./Kearny

A 57-year-old male was admitted to the hospital with a chief complaint of substernal chest discomfort due to swallowing a mouthful of unchewed turkey meat. The patient stated that "it is lodged in the lower chest and will not go down." X-rays confirmed a bolus of meat in the mid to lower third of the esophagus.

Repeated injections of demerol and atropine, and administration of mineral oil were unsuccessful in helping move the impacted meat. Two tablets of papase, followed by warm tea, soon resulted in relief of the chest pain. A repeat barium swallow study substantiated the passage of the impacted meat.

This case is presented as an example of the successful use of an enzymatic digestive agent in preference to the use of endoscopic foreign body removal which may be traumatic and complicated.

ANNOUNCEMENTS

Current Topics in Psychiatry

The Fair Oaks Hospital in Summit announces the following programs in the 1974-1975 series on current topics in psychiatry. Dates and topics of subsequent sessions will be announced in future issues of *The Journal.*

Oct. 9—Psychological Aspects of Asthma
Oct. 23—Drug Addiction
Nov. 6—Meditation as an Adjunct to Psychotherapy
Nov. 20—Diagnosis in the Anemic Patient
Nov. 26—Migrant Adjustment of Refugees

Sessions are held from 3 to 4:30 p.m. in the Conference Room at the Hospital (19 Prospect Street). Granville L. Jones, M.D., Director of Research and Education at Fair Oaks, will be moderator and further information is available by writing directly to him.

The programs are cosponsored by the Academy of Medicine and are accredited for Category I of the AMA Physician's Recognition Award.

Pulmonary Disease Lectures

The Veterans Administration Hospital in East Orange and the New Jersey Medical School, CMDNJ are cosponsors of a 1974-1975 series of lectures in pulmonary diseases, to be held on Wednesdays at 11:30 a.m. at the Veterans Administration Hospital, East Orange, on the dates indicated.

October 16	Aspiration Pneumonia and Lung Abscess
November 20	Histoplasmosis
December 18	Emergency Pulmonary Care
January 15	Rifampin, Tuberculin
February 19	Chemical Control of Respiration
March 19	Cor Pulmonale
April 16	Infectiousness of Tuberculosis before and after Chemotherapy
May 14	Respiratory Failure

Training Program for Emergency Department Physicians

In cooperation with the Inter-Agency Commission on Emergency Medical Care, MSNJ will sponsor a training program for emergency department and other interested physicians in each of the Society's Judicial Districts from 9 a.m. to 4 p.m. on three successive Wednesdays, as indicated. (A similar course has been arranged for nurses at Morristown Memorial, Dover General, St. Peter's (New Brunswick), Jersey Shore (Neptune), and Burlington County Hospitals.)

The series consists of lectures and demonstrations and the subjects included cover resuscitation of the severely injured patient, burns, emergencies of the chest and abdomen, musculoskeletal injuries, the unconscious patient, and psychiatric emergencies.

1st District	November 20 December 4 December 11	St. Elizabeth Hospital Elizabeth
2nd District	December 11 December 18 January 8	St. Joseph's Medical Center Paterson
3rd District	January 29 February 5 February 12	St. Francis Hospital Trenton
4th District	January 8 January 15 January 22	Monmouth Medical Center Long Branch
5th District	November 20 December 4 December 11	The Cooper Hospital Camden

Each course is limited to 100 persons and registration is required. Applications were mailed to each physician last month. The programs have been approved for Category I, AMA Physician's Recognition Award. For further information, please communicate with Jack R. Karel, M.D., Chairman, Inter-Agency Commission on Emergency Medical Care, 115 North Avenue, Hillside, New Jersey 07205.

Pediatric Continuing Education Courses in Florida

The Department of Pediatrics of the University of Miami School of Medicine has announced the following continuing medical education courses to be held in Bal Harbour, Florida this winter:

January 2 to 7—*Dynamics of Progressive Nephropathies, Theoretical and Practical Aspects.* Fee: $175 for practicing physicians; $75 for interns or residents; $100 for nurses.

January 29 to 31—*Human Diseases Related to Food and Chemical Sensitivity.* Fee: $175 for practicing physicians; $75 for interns or residents: $100 for nurses.

March 11 to 14—*Hypertension, Diabetes and Hyperlipidemia in Childhood and Vascular Disease in the Adult.* Fee: $175 for practicing physicians; $30 for interns or residents; $50 for nurses.

For information, please write to the Division of Continuing Medical Education, University of Miami School of Medicine, P.O. Box 520875 Biscayne Annex, Miami, Florida 33152.

Seminar in Neurology

The Department of Neurology of the University of Miami School of Medicine is sponsoring a graduate seminar in neurology—"A Modern Practical Approach to Neurological Medicine"—from March 10 to 14, 1975 at the Fontainebleau Hotel in Miami Beach. Application has been made to the American Academy of Family Practice for 22½ hours of credit. Registration fee is $175 for practicing physicians; $75 for residents; and $125 for nurses. Information is available from O. M. Reinmuth, M.D. 1200 NW 10th Avenue, Miami, Florida 33136.

MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

Oct.

7, 14, 21 **Distinguished Lectures in Surgery**
4-5 p.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

9, 16, 23, 30 **Distinguished Lectures in Neuroscience**
10:30-11:30 a.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

9 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)

9 **Metabolic Acidosis and Related States**
16 **Thyroid Problems in Practice**
23 **Sexual Dysfunction**
30 **Neonatal Medicine**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

9 **Psychodynamics and Treatment of Male Homosexuality**
8-10 p.m.—Englewood Hospital, Englewood
(Sponsored by Academy of Psychoanalysis of New Jersey and Academy of Medicine)

10 **Myocardial Infarction**
8-9 p.m.—Deborah Heart and Lung Center, Browns Mills
(Sponsored by Burlington County Medical Society and Academy of Medicine)

11-14 **Annual Convention—AAFP**
Los Angeles, California

12, 19, 26 **Orthopedic Surgery**
8:30 a.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

12, 19, 26 **Basic Science for Surgeons**
10 a.m.-12 noon—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

15-18 **Review of Obstetrics**
9 a.m.-5 p.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School)

15 **Renal Failure**
1 p.m.—Ancora Psychiatric Hospital, Hammonton
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

16 **Renal Failure**
9:30 a.m.—Bergen Pines Hospital, Paramus
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

16 **Renal Failure**
10 a.m.—St. James Hospital, Newark
(Sponsored by Nephrology Society of New Jersey and New Jersey Regional Medical Program)

16 **Aspiration Pneumonia and Lung Abscess**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

16, 23, 30 **1974-75 Medical Lecture Series**
9-11 a.m.—Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and Academy of Medicine)

23 **Rheumatic Diseases Workshop**
9 a.m.-3 p.m.—Rutgers Medical School, Piscataway
(Sponsored by New Jersey Rheumatism Association and AAFP)

Nov.

2, 9, 16, 23, 30 **Orthopedic Surgery**
8:30 a.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

2, 9, 16, 23, 30 **Basic Science for Surgeons**
10 a.m.-12 noon—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

4 **Fluid and Electrolyte Imbalance**
8 p.m.—Community Memorial Hospital, Toms River
(Sponsored by Academy of Medicine)

4 **Clinical Immunology**
11:30 a.m.—Helene Fuld Hospital, Trenton
(Sponsored by Academy of Medicine)

4, 11, 18, 25 **Distinguished Lectures in Surgery**
4-5 p.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

6, 13, 20, 27 **Clinical Endocrinology**
3:30 p.m.—Martland and Beth Israel Hospitals, Newark, and VA Hospital, East Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

6 **Monthly Meeting—N.J. Gastroenterological Society**
8-10 p.m.—St. Elizabeth Hospital, Elizabeth
(Sponsored by N.J. Gastroenterological Society and Academy of Medicine)

6 **Distinguished Lectures in Neuroscience**
13 10:30-11:30 a.m.—VA Hospital, East Orange
20 *(Sponsored by CMDNJ, New Jersey Medical*
27 *School, and Academy of Medicine)*

6 **Chemotherapy of Malignant Disease**
10 a.m.—St. James Hospital, Newark
(Sponsored by Academy of Medicine)

6 **Management of Renal Failure**
2 p.m.—Christ Hospital, Jersey City
(Sponsored by Academy of Medicine)

6 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

6 **Early Complications of Pregnancy**
13 **Hypothalamic Releasing Factors**
20 **Chemotherapy of Cancer**
27 **Disorders of Lower Esophagus**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

6 **1974-75 Medical Lecture Series**
13 9-11 a.m.—Riverview Hospital, Red Bank
20 *(Sponsored by Riverview Hospital and the*
27 *Academy of Medicine)*

9 **Surgical Symposium**
9-12 noon—Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and Academy of Medicine)

12 **Differential Diagnosis of Arthritis**
8 p.m.—Paul Kimball Hospital, Lakewood
(Sponsored by Academy of Medicine)

13 **Myocardial Infarction—Critically Ill Patient**
2 p.m.—Cherry Hill Medical Center, Cherry Hill
(Sponsored by Academy of Medicine)

13 **Symposium on Emergency Medicine**
14 Cherry Hill Inn, Cherry Hill
(Sponsored by New Jersey Chapter, ACS)

13 **Hyperlipidemia**
8:30-10 p.m.—East Orange General Hospital
(Sponsored by East Orange General Hospital and Academy of Medicine)

13 **Death and Dying**
9-10-30 p.m.—Veterans Administration Hospital, East Orange
(Sponsored by Lewis H. Loeser Memorial Foundation and Academy of Medicine)

13 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)

13 **Regional Meeting, American College of Physicians,** Rutgers Medical School, Piscataway

14 **Diagnostic Ultrasound**
8-9 p.m.—Mount Holly Medical Center
(Sponsored by Burlington County Medical Society and Academy of Medicine)

15 **Proper Use of Antibiotics**
12 noon—Freehold Area Hospital, Freehold
(Sponsored by Academy of Medicine)

16 **Diabetes Today and Tomorrow**
9:30 a.m.-5 p.m.—St. Michael's Medical Center, Newark
(Sponsored by N.J. Diabetes Assn. and AAFP)

19 **Medical-Legal Aspects of Surgery and Anesthesiology**
6-9 p.m. (dinner meeting)—Ramada Inn, Clark
(Sponsored by New Jersey Society of Anethesiologists and Academy of Medicine)

19 **Diagnosis in Anemic Patient**
11:30 a.m.—St. Mary's Hospital, Orange
(Sponsored by Academy of Medicine)

20 **Difficult Diabetic Patient**
10 a.m.—St. James Hospital, Newark
(Sponsored by Academy of Medicine)

20 **Congestive Heart Failure**
1 p.m.—Trenton Psychiatric Hospital, Trenton
(Sponsored by Academy of Medicine)

20 **Difficult Diabetic Patient**
1:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(Sponsored by Academy of Medicine)

20 **Drug Addiction**
3 p.m.—Fair Oaks Hospital, Summit
(Sponsored by Academy of Medicine)

20 **Histoplasmosis**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

26 **Drug Addiction**
11 a.m.—Greystone Park Psychiatric Hospital, Greystone
(Sponsored by Academy of Medicine)

Dec.

2 **Distinguished Lectures in Surgery**
9 4-5 p.m.—Martland Hospital, Newark
16 *(Sponsored by CMDNJ, New Jersey Medical*
23 *School, and Academy of Medicine)*
30

4 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

4 **Clinical Endocrinology**
11 3:30 p.m.—Martland Hospital, Newark, Beth
18 Israel, and VA Hospital, East Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

4 **Office Proctology**
11 **Androgen and Virilizing Syndromes**
18 **Mineralocorticoid Hypertension**
9-11 a.m.—Middlesex General Hospital New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

4 **1974-75 Lecture Series**
11 9-11 a.m.—Riverview Hospital, Red Bank
18 *(Sponsored by Riverview Hospital and Academy of Medicine)*

7 **Annual Meeting, New Jersey Chapter, ACS**
Morristown Memorial Hospital, Morristown

7 **Basic Science for Surgeons**
14 10 a.m.-12 noon—Martland Hospital, Newark
21 *(Sponsored by CMDNJ, New Jersey Medical*
28 *School, and Academy of Medicine)*

7 **Orthopedic Surgery**
14 8:30 a.m.—Martland Hospital, Newark
21 *(Sponsored by CMDNJ, New Jersey Medical*
28 *School, and Academy of Medicine)*

11 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)

18 **Emergency Pulmonary Care**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

1975
Jan.
4 **Orthopedic Surgery**
11 8:30 a.m.—Martland Hospital, Newark
18 *(Sponsored by CMDNJ, New Jersey Medical*
25 *School, and Academy of Medicine)*

4 **Basic Science for Surgeons**
11 10 a.m.-12 noon—Martland Hospital, Newark
18 *(Sponsored by CMDNJ, New Jersey Medical*
25 *School, and Academy of Medicine)*

6 **Distinguished Lectures in Surgery**
13 4-5 p.m.—Martland Hospital, Newark
20 *(Sponsored by CMDNJ, New Jersey Medical*
27 *School, and Academy of Medicine)*

8 **1974-75 Medical Lecture Series**
15 9-11 a.m.—Riverview Hospital, Red Bank
22 *(Sponsored by Riverview Hospital and the*
29 *Academy of Medicine)*

8 **Drug Management of Coronary Arterial Disease**
15 **Portal Hypertension**
22 **Inflammatory Bowel Disease**
29 **Common Disease of Travelers**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

8 **Clinical Endocrinology**
15 3:30 p.m.—Martland Hospital, Newark Beth
22 Israel, and VA Hospital, East Orange (varies)
29 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

8 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by New Jersey Radiological Society and Academy of Medicine)

10 **Portal Hypertension**
12 noon-4:30 p.m.—Hamilton Hospital, Trenton
(Sponsored by Hamilton Hospital)

14 **Renal Failure**
8 p.m.—Paul Kimball Hospital, Lakewood
(Sponsored by Paul Kimball Hospital and Academy of Medicine of New Jersey)

15 **Rifampin, Tuberculin**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

21 **Cardiac Surgery and Anesthesiology**
6-9 p.m. (dinner meeting)—Ramada Inn, Clark
(Sponsored by New Jersey Society of Anesthesiologists and Academy of Medicine)

Feb.
1 **Orthopedic Surgery**
8 8:30 a.m.—Martland Hospital, Newark
15 *(Sponsored by CMDNJ, New Jersey Medical*
22 *School, and Academy of Medicine)*

1 **Basic Science for Surgeons**
8 4-5 p.m.—Martland Hospital, Newark
15 *(Sponsored by CMDNJ, New Jersey Medical*
22 *School, and Academy of Medicine)*

3 **Distinguished Lectures in Surgery**
10 4-5 p.m.—Martland Hospital, Newark
17 *(Sponsored by CMDNJ, New Jersey Medical*
24 *School, and Academy of Medicine)*

5 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 **Clinical Endocrinology**
12 3:30 p.m.—Martland Hospital, Newark Beth
19 Israel, and VA Hospital, East Orange (varies)
26 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

5 **Common Protozoal and Fungal Infections**
12 **Future of Allergy**
19 **Hemostasis**
26 **Hypercalcemia and Hyperparathyroidism**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

5 **1974-75 Medical Lecture Series**
12 9-11 a.m.—Riverview Hospital, Red Bank
19 *(Sponsored by Riverview Hospital and the*
26 *Academy of Medicine)*

12 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and the Academy of Medicine)

19 **Chemical Control of Respiration**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

Mar.
1 **Orthopedic Surgery**
8 8:30 a.m.—Martland Hospital, Newark
15 *(Sponsored by CMDNJ, New Jersey Medical*
22 *School, and Academy of Medicine)*
29

1 **Basic Science for Surgeons**
8 10 a.m.-12 noon—Martland Hospital, Newark
15 *(Sponsored by CMDNJ, New Jersey Medical*
22 *School, and Academy of Medicine)*
29

3 **Distinguished Lectures in Surgery**
10 4-5 p.m.—Martland Hospital, Newark
17 *(Sponsored by CMDNJ, New Jersey Medical*
24 *School, and Academy of Medicine)*
31

5 **1974-75 Medical Lecture Series**
12 9-11 a.m.—Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and the Academy of Medicine)

5 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 **Clinical Endocrinology**
12 3:30 p.m.—Martland Hospital, Newark Beth
19 Israel, and VA Hospital, East Orange (varies)
26 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

5 **Heart Block and Syncope**
12 **Renal Failure**
19 **Resuscitation in Shock and Trauma**
26 **Office Urology**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

12 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and the Academy of Medicine)

19 **Cor Pulmonale**
11:30-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

Apr.
2 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

2 **Common Errors in Practice**
9 **Medical Hypnosis**
16 **Functional Diseases**
23 **Interaction of Drugs Used in Cardiac Disease**
30 **Stroke Rehabilitation**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

2 **Clinical Endocrinology**
9 3:30 p.m.—Martland Hospital, Newark Beth
16 Israel, and VA Hospital, East Orange (varies)
23 *(Sponsored by CMDNJ, New Jersey Medical*
30 *School, and Academy of Medicine)*

5 **Orthopedic Surgery**
12 8:30 a.m.—Martland Hospital, Newark
19 *(Sponsored by CMDNJ, New Jersey Medical*
26 *School, and Academy of Medicine)*

5 **Basic Science for Surgeons**
12 10 a.m.-12 noon—Martland Hospital, Newark
19 *(Sponsored by CMDNJ, New Jersey Medical*
26 *School, and Academy of Medicine)*

7 **Distinguished Lectures in Surgery**
14 4-5 p.m.—Martland Hospital, Newark
21 *(Sponsored by CMDNJ, New Jersey Medical*
28 *School, and Academy of Medicine)*

9 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and the Academy of Medicine)

16 **Tuberculosis Before and After Chemotherapy**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

May
3 **Orthopedic Surgery**
10 8:30 a.m.—Martland Hospital, Newark
17 *(Sponsored by CMDNJ, New Jersey Medical*
24 *School, and Academy of Medicine)*

3 **Basic Science for Surgeons**
10 10 a.m.-12 noon—Martland Hospital, Newark
17 *(Sponsored by CMDNJ, New Jersey Medical*
24 *School, and Academy of Medicine)*
31

5 **Distinguished Lectures in Surgery**
12 4-5 p.m.—Martland Hospital, Newark
19 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

7 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 **Clinical Endocrinology**
14 3:30 p.m.—Martland Hospital, Newark Beth
21 Israel Medical Center, and VA Hospital, East
28 Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 **Minor Surgery in Office Practice**
14 **Learning Disabilities**
21 **Nutrition of the Aged**
28 **Emotional Aspects of Common Medical Problems**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital)

14 **Respiratory Failure**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

Where We Stand

Where We Stand, a pamphlet delineating MSNJ's official position on medical and health issues, is available upon request from the Public Relations Office, MSNJ, P.O. Box 904, Trenton, New Jersey 08605.

OBITUARIES

Dr. John J. Haney

On August 10, 1974, John J. Haney, M.D., a member of our Mercer County component, died at St. Francis Medical Center where he had long been a member of the surgical staff. Born in 1905, he received his doctor of medicine degree from the medical college of the University of Maryland in 1929. After internship, he took a residency in surgery at the Graduate School of Medicine of the University of Pennsylvania and then returned to his native city of Trenton to establish a surgical practice. Dr. Haney was a Fellow of the American College of Surgeons, the American Society of Abdominal Surgeons, the International College of Proctology, and the International College of Surgeons. He was interested in industrial medicine and had been medical director for American Bridge Company and American Steel and Wire Company in Trenton for 35 years.

Dr. Samuel I. Kooperstein

Word has been received of the death on July 13, 1974, of Samuel I. Kooperstein, M.D., a retired member of our Hudson County Medical Society. Born just after the turn of the century, Dr. Kooperstein earned his M.D. degree at the Medical College of New York University in 1926 and following internship came to Jersey City to establish a practice in internal medicine, eventually becoming board certified in that field. He was a Fellow of the American College of Physicians and the American College of Cardiology and held membership in the American Diabetes Association, the American Thoracic Society, and the Academy of Medicine of New Jersey. Dr. Kooperstein had been senior attending in medicine at the Jersey City Medical Center and attending in medicine at Fairmount and Christ Hospitals in Jersey City. He had been medical director for the Port of New York Authority and had served in the medical department of the AUS during World War II.

Dr. Michael J. Kraczyk

One of Middlesex County's senior practitioners, Michael J. Kraczyk, M.D., died on July 27, 1974, at St. Peter's Hospital in New Brunswick. A 1927 graduate of Temple University Medical College, Dr. Kraczyk was a family physician with special interest in endocrinology and had practiced in South River for over 40 years. Dr. Kraczyk, who was 76 years old at the time of his death, had been a captain in the medical department of the AUS during World War II.

Dr. Louis M. Kuhn

On August 10, 1974, Louis M. Kuhn, M.D., died tragically, along with his wife and six children, in an airplane accident in rural Minnesota. Dr. Kuhn, who was piloting his own plane, crashed just short of the runway as he attempted an emergency landing at the fog-shrouded airport at Fergus Falls, Minnesota. It is believed he had run out of fuel. Born in 1929 and a 1960 graduate of the New Jersey Medical School, Dr. Kuhn was a prominent hematologist in Plainfield and was on the staff at the Muhlenberg Hospital there. In addition, he was associated with Green Brook Hospital in Raritan and with Martland Hospital in Newark, and was clinical assistant professor in the division of hematology at the New Jersey Medical School (CMDNJ) and in the department of medicine at the Rutgers Medical School (CMDNJ). Dr. Kuhn had taken graduate work at the Veterans Hospital in East Orange and at the Mount Sinai Hospital in New York before coming to Plainfield in 1964.

Dr. John J. Shaw

Word has just been received of the death on July 5, 1974, of one of our senior practitioners, an emeritus member from Essex County, John J. Shaw, M.D. of Orange. Born in 1907, Dr. Shaw was graduated from the medical school of the University of Maryland in 1932 and following graduate work in dermatology became board certified in that field. He had practiced for many years in the Newark area and had been on the active staff at Presbyterian, Martland, and the Crippled Children's

Hospitals there. Dr. Shaw was a member of the Society for Investigative Dermatology and the New Jersey Dermatological Society.

Dr. Joseph R. Stein

On July 7, 1974, Joseph R. Stein, M.D., Director of Anesthesiology at the Atlantic City Hospital, died at the untimely age of 52. A 1957 graduate of the Medical College of the University of Lausanne (Switzerland), he took residencies at Unity Hospital in Brooklyn and Montefiore Hospital in Pittsburgh and became board certified in anesthesiology. Before coming to Atlantic City, he had practiced in Bristol and Elkins Park and had been a member of the Pennsylvania Medical Society. Dr. Stein also held a degree in dental surgery from Columbia University School of Dental and Oral Surgery. He was a Fellow of the American College of Anesthesiologists and a member of the New Jersey Society of Anesthesiologists, and had served in the USAF as a dental surgeon during World War II.

Dr. Samuel E. Watov

Following a long illness, one of Mercer County's well-known practitioners, Samuel E. Watov, M.D., died on August 26, 1974, at St. Francis Medical Center in Trenton where he had been a member of the staff all of his professional career. Born in 1906, Dr. Watov earned his medical degree at the University of Edinburgh in Scotland in 1932 and returned to his native city to establish a practice in obstetrics and gynecology, becoming board certified in those specialties. In addition to his association at St. Francis Hospital, he was a member of the active staff at the Hamilton Hospital, also in Trenton. Dr. Watov was a Fellow of the American College of Surgeons and of the American College of Obstetricians and Gynecologists, and was a member of the New Jersey Society of Obstetricians and Gynecologists. A veteran of World War II, he received the Purple Heart and Bronze Star for action in the European theatre.

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal, the official organ of The Medical Society of New Jersey, is published monthly under the direction of the Committee on Publication. *The Journal* is released the first week of the month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey, 08605.

Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of material in *The Journal.* All such communications should be directed to the Editorial Office of *The Journal.* The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted.

Contributions: Manuscripts submitted to *The Journal* must be typewritten, *double-spaced* on letter size (about 8½ by 11 inch) paper, and forwarded to the Editorial Office at the address below. The Publication Committee expressly reserves the right to reject any contributions, whether solicited or not, and the right to abbreviate or edit such contributions in conformity with the needs and requirements of *The Journal.* Galley-proofs of edited or abbreviated manuscripts will be submitted to authors for approval before publication. Every care will be taken with the submitted material, but *The Journal* will not hold itself responsible for loss or damage to manuscripts. Authors are required to submit an original and one copy and are urged to keep a carbon for reference. It is understood that material is submitted here for exclusive publication in this *Journal.*

Illustrations: Authors wishing illustrations for their articles will submit glossy prints or original drawings from which cuts can be made. The cost of making such cuts will be borne by the author, who may, after publication, receive the cuts for his own use—*if he makes such a request* in writing to the Editorial Offices.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

P. O. Box 904, Trenton, New Jersey 08605

BOOK REVIEWS

Ethics of Genetic Control. Joseph Fletcher. New York, Doubleday, 1974. Pp. 218. (Softback—$1.95)

This book was written by a very wise 70-year young educator and theologian. He uses rational thought processes (as opposed to the numerous irrational writers on this subject) to explore all aspects of the ethics of genetic control—including chapters on ideas, facts, doubts, issues, answers, and hopes. Unfortunately, rational books on this subject are doomed to the "poorest-seller" list.

Dr. Fletcher bases his ethics on service to human *needs* with individualized management for each specific clinical situation. Thus, his work will be rejected by those who cannot think but prefer to deal with all-or-none categorical labels. Even cloning is valid for certain specific human problems. *Mass* cloning is not of value because mass stereotyped genes would be detrimental in a constantly changing future environment.

Although there are some minor genetic errors, this thoughtful treatise is highly recommended reading for all individuals—not just physicians—who wish to delve into ethical issues in genetics. It will be of no value to those with deep-seated "prejudices" concerning those issues.

Theodore Kushnick, M.D.

The Ultimate Stranger, The Autistic Child. Carl H. Delacato. New York, Doubleday, 1974. Pp. 226 ($6.95).

The purpose of this short novel-like book is to reveal another viewpoint of the already many theories on the autistic child. This theory comes to us now from Dr. Carl Delacato associated with the Institute for the Achievement of Human Potential in Philadelphia.

The author purports his theory of central organic neurologic deficit as the cause of autism in interesting fashion, differing from others in the field by his systematic classification of "sensoryisms." That is, for each of the five senses, categorically one can theorize the defect is either hyper, hypo, or a continuous feeling the child experiences to explain his multifaceted syndrome. By evaluating the child's behavior, one can then treat the child accordingly.

Dr. Delacato's theory sounds interesting; however, the results of treatment are not statistically stated in the book. Some of his results might also be interpreted as improvement consistent with the natural course of the disease. Also, no clear-cut differential diagnosis with entities, e.g., congenital deafness, aphasia, mental retardation, elective mutism, is made.

The book is written primarily for parents of autistic children but offers little for allied medical personnel. I find the author in several instances lashing out at the "establishment" unnecessarily, especially his treatment of Dr. Kanner, the recognized authority on the subject.

There are better and more objective presentations of the subject in the literature.

Frank C. Vanore, M.D.

Stress Without Distress. Hans Selye. Philadelphia, Lippincott, 1974. Pp. 171. ($6.95)

Hans Selye has devoted a lifetime of work to the question of how living organisms maintain their functional balance while being subject to so many stress-producing factors in the course of everyday life. His work is in the tradition of Claude Bernard and Walter Cannon. Like his great predecessors, Selye ultimately asks whether our biological understanding of stress can guide us in daily life and in living together. His predecessors thought so (as he writes on pages 68-69) and Selye agrees. His conclusions form the body of this book.

Living organisms, he argues, strive for self preservation. Life is basically egotistical. The course of evolution demonstrates that adaptability, i.e., resistance to stress increases by collaboration among cells (multicellular organisms) and collaboration among separate living beings (symbiosis). On a cultural level, between man and man and between people and people, Selye recommends a parallel mechanism: altruistic egotism.

The principle of altruistic egotism implies that in order to feel secure among my fellow men I guide my life to seeking their approval, respect and gratitude, in short to "earning my neighbor's love." I do so in the first place by working. In order to be successful, however, my work must be a source of satisfaction to me. It can be that only if I know myself well enough to choose a vocation according to my pleasure and within my limitations. Such work is a source of constructive stress, strengthening body and mind. Attempts to function beyond my capacity create distress (corresponding to Selye's stage of exhaustion), while life without stress is living death. Selye concludes that the laws of nature appear to serve equally well as ethical guidelines in human culture, thus establishing the basis of a natural philosophy of life.

This reviewer thinks that Selye does not present us with universal ethics but rather with his own personal convictions, the result of a lifetime of creative work and living with people. Whoever respects and admires Selye, the scientist, has a chance to meet him personally in this book. An annotated bibliography enhances the attraction of the volume.

A. Johan Noordsij, M.D.

Handbook of Poisoning, 8th Edition. Robert H. Dreisbach, M.D., California, Lange, 1974. Pg. 517. (Softback —$6.50)

This handbook provides a concise summary of diagnosis and treatment of clinically important poisons; many poisons of lesser clinical importance are included in class tabulations. Desired information is readily located; brand names are included in the index. The book is sectioned into agricultural, industrial, household, and medicinal poisons, and animal and plant hazards. The opening section contains chapters on prevention, emergency management, diagnosis and evaluation, management, and legal and medical responsibility aspects of poisoning. This "General Considerations" section should be read by every physician before he is confronted with his next case of poisoning. It is well organized, well presented, and contains many valuable details of clinical procedures, calculations, analyses, and pharmacology.

A copy of this book should be on hand in the doctor's home and office, and in hospitals.

Hyman W. Fisher, M.D.

Application of Proteolytic Enzymes to Protein Structure Studies. E. Mihalyi. Cleveland, CRC Press, 1972. Pp. 364. ($32.50)

This attractively bound book (reasonably priced for the amount of information it contains) was written in a scholarly manner by a man who has both an M.D. from the University of Kolosysvar, Hungary in 1943, and a Ph.D. from the University of Cambridge, England in 1963. He has worked in muscle research and protein chemistry for many years at the National Institutes of Health. He has been interested in proteolytic processes since 1946. This single-author volume points out his vast knowledge in this field.

About 20 years ago I said in an introductory lecture to medical students in a pathology course that the three key areas in which to watch for rapid developments, as related to medicine were: protein chemistry, genetics, and immunology. This work supports that statement, particularly the first of these three, and the coverage of this difficult subject is complete.

The book is comprised of eight chapters: (1) Introduction, (2) Protein Structure, (3) Proteolytic Enzymes, (4) Enzymatic Proteolysis, (5) Conformation and Proteolysis, (6) Action of Exopeptidases on Native Proteins, (7) Effect of Endopeptidases on Native Proteins-Limited Proteolysis, and (8) Action of Endopeptidases on Native Proteins—Formation of Larger Fragments. Each of these chapters has three major subsections dealing with proteins of current medical importance, such as fibrinogen and its split products, the entire mechanism of the complement system, and the renin-angiotension system.

It is a well-written book and, considering the difficulty of the subject, surprisingly pleasant to read. It is not recommended for medical students or residents, but is strongly recommended for all medical scientists who are interested in protein chemistry. It has been placed on my close-to-hand bookshelf adjacent to the Handbook of Chemistry and Physics also published by the CRC Press.

Hugh F. Luddecke, M.D.

Bedside Diagnosis. Charles Seward. New York, Longman (Churchill-Livingstone Medical Division, London), 1974. Pp. 582. ($14.50)

A medical textbook that has gone through ten editions with continuous revisions and twenty-five years of service deserves attention and respect because it has taught many physicians the elements of their profession. *Bedside Diagnosis,* by the eminent British physician Dr. Charles Seward, is a book which is complementary to the formal textbook in approaching diagnoses.

The first concern of a physician when confronted by the patient is to listen to the symptoms. Interrogation into a proper order of time of onset, duration, and site of origin makes it possible to evaluate these symptoms. Irrelevant matters must be set apart. Questions must be asked that elaborate on facts (either real or fancied) until the significant picture is understood and system of the body identified as the site for study and care. The origin of pain, or fever, or bleeding or whatever it was that brought the patient for help, must be carefully considered and searched.

Such is the scope of this text. Complaints are presented as chapter headings; their various origins are suggested; a course of evaluation follows; then laboratory tests are listed and their diagnoses are left to the sharpness of the physician. The text is written in a manner easily followed—short paragraphs and outline form with different kinds of type to emphasize the facts.

It is well recommended for all physicians who are, indeed, forever students.

Harry M. Poppick, M.D.

Laboratory Skills for Allied Health Occupations. Howard Taub. Corte Madera, California, Rinehart, 1974. Illustrated. Vol. 1, Pp. 287 ($6.95); Vol. 2, Pp. 407 ($7.95)

Volume I: The volume presents laboratory tasks in a manner of utmost simplicity. We can compliment the author on the table of the elements with names and dates of the discoverers. The sections on solutions, their preparation and associated calculations, are presented in great detail. Simplification seems to be the key word in this volume.

The impression is gained that the author has tried to make the information so accessible that even the brain of an amoeba (if it had one) could assimilate the material. Lowering of standards is suggested when solutions are prepared from graduate measurements. Why not use a burette? This apparatus fails to be mentioned in the text.

Weighing directions are given in great detail. Use of the analytical balance is illustrated. All this leads the reviewer to wonder why, in this day of prepared laboratory test kits, disposable glassware, and diagnostic reagents, any of this material has a valid base.

Then on the first page we read, "Research and Demonstration Grant 8-0627 U.S. Office of Education, Bureau of Research, Department of Health, Education, and Welfare." The American taxpayer is easily the world's greatest push-over (according to Webster).

Volume II: This volume again provides simplified instructions for the embryo assistant in blood collecting techniques. The illustrations on page 56 are crude and not considered as representative of normal red blood cells. The material would be beneficial to most assistants working at the present time as few have even a modicum of experience and no training.

Instructions for preparing blood smears, collecting cerebrospinal fluid, gastric and duodenal fluids and urine are detailed. The elementary tone of the material is gathered from such loose statements as on page 101, "peritoneal fluid which collects in the intestinal cavity". (This suggests a new H.E.W. type anatomy).

Comments on specimen identification and laboratory distribution are good. The illustrations are amateur. Instructions for calibrating centrifuges, mailing specimens to reference laboratories are noted.

The section on media is introduced with due apology to those laboratories using prepared media. The reviewer regards the material as suitable for workers in large public health installations. Again my sympathy pours out for the general practitioner and the lowly patient.

Both volumes of this series are doomed to repose on library shelves, unnoticed.

Thomas K. Rathmell, M.D.

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EDITORIALS

Life Month

November is the seventeenth "Life Month" for our original Nationwide Life Insurance Program. Over $2,800,000 has been paid to beneficiaries. Up to $150,000 or 15 units of coverage are available under the plan. Each unit of insurance provides $10,000 of death protection with double indemnity in case of accidental death, as well as a guaranteed conversion provision and a waiver of premium provision without extra charge.

Inflation has made additional insurance protection a necessity. Our low-cost, non-cancellable plan makes it easier for members to provide adequately for their families especially since issuance has been simplified and in many cases applicants no longer need physical examinations.

A special "Life Month" mailing is being sent this month by our Administrator, E. & W. Blanksteen Agency, Inc. Look for your application in the mail. The Administrator will be happy to provide help and information as to the best uses of the total program for your circumstances. D.B.

Why Diabetes Week?

In anti-rhetorical fashion, one might answer: Why not Diabetes Week? One may then answer that question with more questions.

1. If no diabetes detection, how will we conduct epidemiological studies of diabetes?

2. How will we learn more about Viral Insulitis and its effect on genetically defective beta cells?

3. How can we find out about insulin receptors, the specific elements of cell membranes which bind insulin and somehow initiate its biological effects?

4. On whom will we study C-peptide levels and their correlation with circulating insulin?

5. Can Diabetes Week tell us anything about beta cell transplantation and development of beta-cell banks?

6. Will Diabetes Week have an influence on laser therapy of retinopathy, on the evaluation of vitrectomy, and the use of E.R.G.?

7. Will the glucose sensor and the artificial pancreas have anything to offer during Diabetes Week?

The answers to all these questions have nothing to do with Diabetes Week — November 11-17. They show only that diabetes is a fascinating disorder and that new things are happening. A.K.

Journal Staff Enlarged

Breadth and depth of medical knowledge describe the additional *Journal* staff just appointed by the Board of Trustees. Three Associate Editors (see page 871) and a Manuscript Review Board (see page 810) will bring their massive talents to *The Journal* in the immediate future. The result will be a higher quality of published material with fresh concepts and new features.

Along with our Book Review Board, whose contributions have been quiet but magnificent, we will then have a sizable portion of MSNJ membership participating in the life of *The Journal*. Our aim is simple: to publish a scientific magazine whose quality and interest levels are so high that our members will look forward to reading it as a primary source of statewide information and educational material.

As always, we welcome suggestions from all of you for ways to improve the *JMSNJ*. A.K.

Don't Forget the Patient

As part of a seeming mad rush to improve the quality of health care, new delivery and financing systems and new techniques for record-keeping, analysis, evaluation, storage, and retrieval of data have burst forth. With this phenomenon has come a new vocabulary and, with it, the inevitable alphabetical symbolization. These include Problem Oriented Medical Records (POMR), Professional Services Review Organization (PSRO) and Health Maintenance Organization (HMO). Some phrases are emotionally charged—National Health Insurance (N.H.I.). Some are acronyms, such as S.O.A.P.

As with everything new, there are proponents and opponents, advantages and disadvantages, and such is certainly the case for the Problem Oriented Medical Record system developed by Weed.[1] Many physicians have been exposed to POMR and at least have a speaking knowledge of the concept, but most clinicians and hospitals are still using the source-oriented system. The fundamentals of POMR are the Data Base, the Problem List, the Initial Plan, and the Progress Notes. The Data Base includes a patient profile and related social data, history, and systems review, the patient's chief complaint and present illness, the results of the physical examination, and the reports of laboratory and screening tests. The elements of the Data Base are conventional, but from this point differences appear.

The Problem List is derived from the Data Base, and each problem identified is assigned a number and date. When new problems appear, they are added to the Problem List. A problem is defined as something that concerns the patient, the physician, or both, and may include a complaint or symptom, a physical abnormality, an abnormal laboratory test, or a psychological or socioeconomic problem. When problems are converted to diagnoses, they are carried as such in the Active or Ongoing Problem List if they are chronic, and on an Acute Self-limited Problem List if they are temporary.

The Initial Plan for each problem consists of appropriate techniques to obtain further data to establish a diagnosis, plans for treatment, and plans for educating the patient about his illness and his part in managing the problem. The final element, Progress Notes, are the "feedback loop" which chronologically relates the patient's course to the Data Base, Problem List, and Initial Plan. The S-O-A-P system for recording Progress Notes, meaning subjective findings, objective findings, assessment, and plans, is related to each numbered problem. The flow from visit to visit, from doctor to doctor ought to be smooth with the Weed system.

There is a danger, however, in this concept which we must keep in mind. That risk is the possibility that one can get so imbued with the records-keeping system that he may lose track of the patient. After all, the physician must treat patients and, whether he uses a source-oriented or problem-oriented records system, the patient remains the central character in the drama. Source-oriented records are not "anathema" and problem-oriented records are not utopian. It is important for the physician to be organized and systematic, but he must remain warm and human. He can never approach the organization of the computer, but, thankfully, the computer cannot compete with the physician's humanitarianism.

New concepts do not mean that old fundamentals are to be abandoned forthwith. The new physicians, the current medical students, and house officers are being trained in the POMR approach. This is fine, and as it should be. The "less-new" physicians may find the transition a bit hard, especially where they have accumulated a 20-year file of source-oriented records in their office practices. It will be important for all to keep an open mind, to be patient, and to be willing to change. With it all, however, please do not forget the patient. A.K.

(See related article—page 872)

1. Weed L. L: The Problem-oriented record as a basic tool. *Medical Records, Medical Education, and Patient Care*. Chicago, Year Book Medical Publishers, Inc., 1970.

ORIGINAL ARTICLES

After an historical review of the subject, the author concludes that a diagnosis of "burn encephalopathy" is a tacit admission of inability to identify the responsible etiologic factor.

Burn Encephalopathy as a "Diagnosis"

Fred A. Mettler, M.D./Blairstown

In a previous article, reference to the phrase "burn encephalopathy"[15] has evoked a number of inquiries as to where one can find a description of this "diagnosis."

"Unofficial" diagnoses. Burn encephalopathy and related circumlocutions, such as "encephalitis, blindness, or myelitis, following burn," are among terms found in the clinical literature but not recognized by inclusion in formal nosologies such as the International Classification of Diseases. It differs from a diagnosis such as lead encephalopathy in that it designates neither a specific type of structural neuropathologic change associated with a definite causal agent, nor a relatively characteristic clinical state (such as saturnism) associated with the alleged cause.

The belief that involvement of the neural system is responsible for a significant role in burn mortality can be traced to Dupuytren's emphasis upon severe pain as a cause of death. Marchand reviewed the 19th century literature and explained that Dupuytren's theory assumed that the shock and accompanying alterations in blood pressure and respiration which follow severe burns were due to neural reflex paralysis, but subsequent experiments on spinal shock failed to elicit symptoms identical with those seen in burn patients.[14] Marchand also reviewed a number of inconclusive reports of structural alterations in Nissl substance in the peripheral and central neural system of burn cases and noted that alternative, non-neural explanations for burn symptomatology postulated disturbances in metabolism or intoxication with the decomposition products of thermal damage. He seems to have taken it for granted that informed pathologists were aware that the leptomeninges and neural substance of the brain showed marked venous congestion, with reddish discoloration of gray matter and edema, even in cases where the head had not been burned and in patients dying within 24 hours after the accident. Marchand pointed out, however, that not all fatal burn cases exhibited cerebral edema, but thought this was because of lesser severity of the burn. He knew there was massive edema of the lungs in many burn cases, but apparently did not recognize the particular hazard associated with laryngeal edema. He realized that fat embolism might occur if bones were burned, but he did not attribute any of the neurologic signs (as he understood that phrase) to such a condition.

After Marchand's time, reference to neurologic symptoms specifically meant headache, nausea, vomiting, twitching of muscles and even convulsions. These had long been known to occur in children who had suffered extensive burns, regardless of the location of the areas involved. Convulsions were known to be indicative of a particularly poor prognosis, since such children generally died on the fourth or fifth day. As was later discovered, death did not occur if the electrolyte disturbance, which is the usual cause of early cerebral edema and convulsions, was corrected.[8] Pediatricians believed such convulsions were due to the high fever such children had and the "toxemic" theory was given broader credence. Ordinarily, if burned children who had convulsions did not die, they recovered

without any neurologic residuals; when the children came from socially deprived backgrounds a pattern of mental retardation and antisocial behavior emerged in an occasional child. Investigation of some cases of this type has convinced this writer that mental deficiency is not infrequently a predisposing factor to burns and that the alleged parents may have limited intelligence or definitely psychopathic patterns of behavior, and react to the accident and its consequences in such a way as to further aggravate its psychologic effect. These phenomena are also seen in parallel traumatic situations, not involving burns, and in cases of lead and other poisoning.

In the years of World War I and immediately thereafter, the epidemics of influenza, and more especially von Economo's encephalitis, redirected interest to the neural system and led to a clearer idea of what could be expected by way of symptoms of brain involvement. In 1928, Kruse reported the case of a 14-month-old child who, after having been burned by hot coffee, was treated with a salve of unspecified nature.[11] Early the next day, it developed opisthotonos and convulsions, followed that afternoon by another spell of convulsions lasting two hours. The child had fever for two days associated with some twitching around the mouth and eyes and was found to be blind. Amaurosis cleared after three months, but the child continued in a retarded state, exhibiting head-banging and temper tantrums. Encephalography disclosed increased filling, with air over the surface of the brain. Kruse considered the possibilities of toxemia, uremia, and carbon monoxide poisoning, but concluded that the convulsive state and blindness were due to cerebral edema and the retarded condition to "encephalitis" secondary to edema.

The three pathophysiologic stages of the burn syndrome. As early as 1833, George Ballingill divided the burn syndrome into three stages with patients dying soon (from "causes we cannot explain"), in ten to twelve days because of fever, and three to six weeks after the injury, by "sinking into a hectic state" (i.e. infection).[4] More recently, Arturson (1961) characterized the pathophysiologic stages through which the patient passes: phase 1, increase of capillary permeability; phase 2, intoxication with cellular degeneration of parenchymatous organs; and phase 3, exhaustion.[2] From the point of view of neurologic symptomatology and treatment, it is useful to view the first phase, which may last up to two days, as one of shock with acute circulatory insufficiency and acute congestion of all organs, as manifested by pulmonary edema, hypoalbuminemia, decreased blood pressure, and anuria. The second phase, which lasts from 2 to 9 days, is characterized by imbalance of body fluids and infection. In the third phase, which lasts up to 24 days, there is increased susceptibility to stress and infection. Patients dying in this stage exhibit marked structural changes in the cardiovascular system, kidney, lung, liver, and adrenals. Renal failure continues to be a problem beyond the third phase.

The neural symptoms of the first two stages of burn syndrome. During the first day, the behavior of seriously burned children is generally more or less consistent and unrelated to individual personality differences. Initially, the child is relatively composed, alert, and cooperative, and complains of little or no pain.[16] Thirst is prominent. As vasoconstriction occurs, the child complains of being cold. Nausea and vomiting may occur with relatively little concern, but headache may be disturbing. If cerebral anoxemia develops, drowsiness appears. As the first phase draws to a close, plasma volume decreases, and, if uncompensated electrolyte imbalance is uncorrected, cerebral edema develops, and restlessness, sudden movements, shouting, and mental confusion may alternate with drowsiness. These phenomena can be abolished by appropriate intravenous therapy. The appearance of this second phase is often sudden and is usually ushered in by sustained fever, increased depth and rate of respiration, and moderate, sustained hypertension. In cases studied prior to 1946 (i.e. prior to the systematic, vigorous use of replacement therapy) the usual duration of the signs of neural involvement of the first two phases was about

two to three days, and seldom more than ten.[16] At the present time, the number of cases entering the second stage should be limited to those with severe burns.

Introduction of word "encephalopathy". In 1928 (the same year in which Kruse spoke of encephalitis resulting from brain edema due to burn), Oppenheimer and Fishberg introduced the word encephalopathy to explain the headache, coma, convulsions, amaurosis, hemiplegia, and aphasia encountered in hypertensives.[19] Although these authors were unable to bring forward any evidence of structural neuronal changes in hypertensives and their basic concept has been discarded, the envelope concept of encephalopathy, as a term to designate "structural changes in the brain," became popular. As is usually the case with brief, vague generalizations, they may displace more specific and meaningful designations, such as the "acute hemorrhagic superior polioencephalitis" of Wernicke.

In 1936, Globus and Bender applied the phrase "disseminated encephalopathy" to the case of a child who survived a burn for six months and who had a protracted course which differed from that of Kruse's patient.[9] The histological material from this patient disclosed structural changes which could not be reconciled with Kruse's diagnosis of encephalitis. This eight-year-old boy who had been treated with morphine, intravenous glucose, and dressings of tannic acid, progressed well except for massive purulent infection beneath the tanned areas. After seven weeks of a relatively uneventful recovery, the temperature suddenly rose to 105.8, the spleen and right kidney were palpable, the hemoglobin fell to 56 percent, and vomiting occurred. Periarterial sympathectomy was carried out eight weeks after the accident (the nature of the anesthetic was not stated). The patient's condition declined thereafter with persistent anemia, emaciation, exhaustion, despondency, thrombophlebitis, and generalized edema. No renal function studies seem to have been done (hepatic function studies were not yet common) and urinary findings were not given. At autopsy, infarcts in the kidneys and spleen and fatty degeneration of the liver were found. The central neural system showed sharply demarcated degenerative lesions, usually beside a blood vessel, as well as generalized fatty degeneration with fat-loading of perivascular spaces. Globus and Bender likened these changes to those encountered in animals injected with horse serum, potassium cyanide, or tetanus antitoxin in efforts to produce experimental multiple sclerosis. They shrewdly concluded that their case supported a "toxemic theory." In calling attention to the time lag in the development of symptomatology and by stating that the neuropathic findings could not have been predicted from the patient's early clinical condition, it was implied that the toxin was a protein degradation product which had produced an allergic reaction. The possible influences of the septicemia and hepatic and renal damage were not discussed.

Subsequently, considerable attention was directed to the detection of a specific "burn toxin" and the autoimmune paradigm continued to enjoy considerable popularity until attention in the field of demyelinizing diseases shifted to the possibility of a slow virus etiology of multiple sclerosis. There were, however, alternative possibilities.

Hidden causes of intoxication. Increased intracranial pressure is a common feature of toxic conditions and was long known to occur in lead and arsenic poisoning. In view of what is now known about the management of burn patients, and the dramatic improvements which occurred when perceptive intravenous regulation of fluids and electrolytes was introduced in conjunction with antibiotic therapy, it is worth recalling treatment of burns in the late nineteenth century. Like other wounds, burns were subjected to phenolic-antiseptic "Listerian routines" (1/20 aqueous solution for skin preparation and 1/40 for deep irrigation). Lister knew that phenol was "imbibed" in "poisonous" quantities in the circulation and that it produces "obstinate vomiting"; if he was aware of the full range and nature of

its toxicity, he does not seem to have discussed this and certainly tended to minimize hazards.[12] By 1875 Lister was also employing a saturated solution of boric acid. The subsequent parade of potentially toxic substances is impressive. "In 1900, gauzes treated with no less than fifteen antiseptics were listed by one manufacturer. The chief antiseptics used for gauze were boric acid, carbolic acid, alembroth" (a double chloride of ammonium and mercury), "cyanide and later picric acid for burns."[5] Bishop might have also mentioned iodoform (triiodomethane), thymol, aristol (thymol iodide), acetanilid, mercuric chloride, and eucalyptol.

World War I saw the introduction of closed dressings of cod liver oil or Carrel mixture, paraffin oil, beeswax, and castor oil, which encouraged gas gangrene, the Carrel-Dakin (sodium hypochlorite) irrigation technique and, in 1925, "open treatment" with the tannic acid spray. McClure pointed out that this technique produced hepatic pathology. It should be recalled that Globus and Bender's patient had definite hepatic degeneration. In 1942, Allen and Koch returned to closed dressings of petrolatum, but Liedberg, Reiss, and Artz showed that staphylococcal septicemia, developing from infections under closed dressings) was the primary cause of death in 1953. Antibiotic therapy was introduced whereupon the common infecting agent changed to pseudomonas; it was subsequently discovered that tetracycline, nalidixic acid, steroid therapy, and steroid withdrawal could all produce increased intracranial pressure.[18,22]

Most of the cases from which the concept of burn encephalopathy was developed belong to the decade from 1928 to 1938 when tannic acid was still the popular treatment of burns and massive infection was very common. We must now direct our attention to those cases which can be retrospectively fitted into patterns of secondary disturbance due to a lack of control of the first two phases of the burn syndrome.

Delayed evidence of neural involvement. Toward the end of the "tannic acid era," presumptive neuropathologic involvement of delayed burn damage of the neural system was more frequently reported. In 1940, one year before hexachlorophene was patented, Roth published a case report in which a child went through the vicissitudes of the first two stages of the burn syndrome while being treated with intravenous medication and tannic acid. She was making a good recovery in the third week, during which no neurologic abnormalities were apparent, when she suddenly went into coma, with generalized convulsions, fever to 107 degrees, tachycardia, and tachypnea. After unspecified "supportive measures," the critical situation subsided but the patient was found to be "extremely irritable and unable to speak or recognize objects." This situation did not materially improve over the next three months and athetoid movements of the right hand developed.[21] Although the record presented is inconclusive, it is not improbable that this patient had hepatic damage due to tannic acid* even though liver function tests, which were conducted much later, were normal.

In 1947, Hughes offered a provisional diagnosis of "demyelination following a burn" in an Australian child who had 50 percent first and second degree surface involvement.[10] The patient, who evidently was still alive when the report was published, had no obvious gross fluid imbalance and no notable infection. The response to treatment was excellent, drugs were discontinued, and the child was playing in its crib on the fifth week. During the sixth week she was found in a decerebrate position, from which she recovered only partially; the residual condition was clinically suggestive of a C-VII cord lesion. This is a different development from that observed in the infected, hyperpyretic cases of Globus and Bender and Roth.[9,21] Although there did not appear to have been any electrolyte imbalance, the report does not tell us whether this child had been treated with hexachlorophene, which had been patented in 1941, and which is now known to be both toxic and absorbable from burned surfaces.

*More fully discussed on page 29 of National Research Council, 1943.

Sundry neuropsychiatric abnormalities. Schachter published a clinical report on four cases of children who exhibited various types of chronic neurologic involvement following burns.[23] These abnormalities varied from convulsive state in one to mental retardation in others. No structural pathologic data were given since the patients survived. In one case, boiling water had been poured directly on the head of an 18-month-old infant; none of the case histories were able to exclude complicating factors.

Between 1928 and 1954, a number of additional clinical descriptions without neuropathologic studies reported neuropsychiatric phenomena in children who had been burned. These add little to what was already observed. The time span covered is variable in these reports, and the authors did not always indicate that they were aware of possible complexities. Walker and Shenkin reported edematous changes in the brain in six patients who died between the third and sixth day following burns.[24] Disorientation, drowsiness, and muscular twitching were attributed to edema. The treatment records were fragmentary, but petrolatum pressure dressings were used and some patients clearly did not have adequate replacement therapy. This is sufficient explanation for the late development or continuance of cerebral edema.

Madow and Alpers considered the relative merits of anoxemic and toxic etiologies of manifestations of disordered cerebral function in a burn patient who survived 16 days after a plane crash, in which a fractured skull was sustained. It is noteworthy that this child developed icterus and a dark amber urine on the tenth day and had a blood pressure of 160/80. The authors state that "newer methods of treatment" had been used; neither tannic acid nor hexachlorophene were mentioned. Autopsy revealed that the brain had a greenish color, was edematous, and exhibited widespread chromatolysis; this is well known to occur when bile salts are absorbed. There were hemorrhages in the adrenal cortex. The authors concluded that the neuropathologic changes were due to edema from a "toxic factor" and discarded anoxia as a possible cause of "burn encephalopathy."[13]

Modern multifactorial period. In 1957, Allgöwer expanded Ballingill's temporal scheme and laid the groundwork for the classification later formulated by Arturson. Allgöwer pointed out that the relatively benign early neuropsychiatric symptoms, such as headache, nausea, and vomiting in the first phase of syndrome, are due to mild anoxemia. This may be a result of asphyxia, carbon monoxide poisoning, or the acute circulatory insufficiency and the accompanying cerebral vascular congestion, which is a part of shock.

With progression into the second stage, brain swelling is augmented by interstitial edema caused by the electrolytic disturbances. Replacement therapy, which had been developed on the basis of a long series of studies beginning with Underhill's work on the Rialto Theater fire victims in New Haven in 1921, is designed to correct the electrolytic imbalance.[3] As vascular insufficiency becomes more pronounced, mental confusion and then convulsions develop. If the second phase continues, coma and/or hyperthermia may occur due to continuing cerebral edema or renal failure and/or infection. Muscular twitching may serve to direct attention to renal damage.[14] Under ordinary circumstances, the nonspecific neurologic phenomena of the first and second phases last two or three days, rarely more than ten.[16]

If a third phase develops, the exhaustion may be associated with continuing convulsions and hyperthermia, abnormal movements, and psychologic disturbances. These may be due to escape from electrolyte balance, infection, or hepatic, renal, and/or adrenal failure. While the nature of early neuropsychiatric signs are unrelated to individual personality differences, pre-existing neuropsychiatric disability, as well as age and social competence of the patient exert appreciable influences on the appearance and nature of subsequent psychologic disturbances. A reappearance of coma, or

the appearance of focal neurologic signs, such as blindness or paraplegia, suggest the redevelopment of edema, either as the result of uncontrolled electrolyte imbalance or interference with cellular enzymatic processes as by a toxic substance. The anoxia, which plays a part in such conditions, is not to be conceived of as due to inadequacy of respired air but rather as an interference with the delivery of oxygen at the molecular level of cell metabolism. Attention must also be accorded the possibility of the initiation of an autoimmune process proceeding to demyelinization, but the demyelinization in most of the articles mentioned here seems to have been a patchy complication of bacteremia with petechial hemorrhages. No doubt there is potentiation between various individual subthreshold hazards. The situation is analogous to what is often seen in carbon monoxide poisoning. If a young, healthy patient recovers from the initial effects of carbon monoxide poisoning, adverse effects cannot ordinarily be detected. It is true that such persons have an elevated incidence of psychiatric disorders later in life, but this may be a reflection of the personality instability which is associated with the population sample susceptible to carbon monoxide poisoning. However, if the patient is old, or the physiology of the neuraxis is otherwise compromised, carbon monoxide poisoning may precipitate convulsive disorder, parkinsonism or mental impairment. The burned patient is in a very vulnerable position, therefore the disadvantages of anesthetics, psychologic stress, and the internal or external use of any of the very large group of substances which depress cellular metabolic function should be carefully weighed against their possible advantages. Efforts to cope with unstable situations may engender further instabilities. Other than vascular engorgement or edema, the earliest of these are biochemical disturbances, which cannot be expected to have any structural neural substrate demonstrable by inspection or ordinary light microscopy.

With a clearer understanding of the general disturbances in physiologic function which burns produce, the tendency to utilize the generalized designation "burn encephalopathy" has disappeared. Use of such a "diagnosis" is a tacit admission of inability to identify the particular responsible etiologic factor or factors. A search of the burn literature of the last decade has not revealed any communications devoted to such a categorization which can be picked up by title search, and there is no rubric for that diagnosis in the usual taxonomies.

Conclusion

The symptomatology (and their causes) which occur in the first and second stages of the burn syndrome have been detailed above. It is not only inappropriate to designate such secondary phenomena as "burn encephalopathy," but the use of that designation diverts attention from the pathophysiology which ought to be the target of therapy. Neither should the phrase be used for the convulsions and sudden death due to edema of the larynx or for the loss of thermoregulatory function which is a consequence of hyperthermia caused by massive infection.

Abnormal neural reactions produced by exposure to neurotoxic substances are not appropriately designated "burn encephalopathy." Since pre-existing neuropsychiatric pathology is more frequent in burned children than in the population at large, we must avoid blaming it on thermal trauma; the experienced pediatric psychiatrist will remain alert to dangerous feedback dynamics which are frequently encountered in families made up of people of limited intelligence or unstable personalities.

At the present time, it is difficult to find a neuropathologist who would be willing to specify criteria for "burn encephalopathy," or who would recognize the phrase as an appropriate description of a definite entity. Modern knowledge of the temporally changing character of the burn syndrome makes it unlikely that any such term will ever regain acceptance, if, indeed, it ever enjoyed it. At best, it is a very vague "diagnosis"—the disappearance of which may be viewed with no appreciable degree of regret.

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Pippin Hill

"Degreasers' Flush" Is Unpleasant New Disease

A new human ailment—"Degreasers' Flush"—is reported in a recent issue of *Archives of Environmental Health,* a publication of the American Medical Association.

Degreasers' Flush an embarrassing but benign health problem, occurs in men who work frequently with trichloroethylene (TCE), a common industrial solvent used to remove grease from machinery and parts. It isn't the solvent alone that causes the problem. It's a combination of exposure to TCE and a stop at the local pub for several beers or a shot of whisky or vodka en route home.

Workmen who used the solvent at the plant, then stopped for drinks after work hours developed vivid red blotches on their faces—Degreasers' Flush. So unsightly has been this skin redness that the workmen shunned taverns to avoid derision, says the research group from the Medical College of Wisconsin.

The flush first occurred after three weeks of daily exposure to TCE vapor. Since all but one of the male subjects did occasionally drink moderate to large amounts of alcohol, it appears that repetitive TCE vapor exposures are required before alcohol can cause the skin response. To avoid Degreasers' Flush, it is necessary either to quit working with the solvent, or quit drinking.

No completely satisfactory technique of managing contaminated abdominal wounds is available at this time. However, a practical method of dealing with this problem by closure of the musculo-aponeurotic layer with figure-of-eight sutures of monofilament polypropylene with delayed primary closure of the skin and subcutancous tissues seems to be the most satisfactory for the present.

Handling of Contaminated Abdominal Wounds

Thomas B. Mervine, M.D., Armando F. Goracci, M.D. and George S. Nicoll, M.D./Woodbury*

Contaminated wounds pose an almost daily problem to the clinical surgeon. Handling such wounds in the best manner is a continuous challenge in the operating theater. The established, accepted principles of wound care include gentle handling of tissues, meticulous hemostasis, avoidance of tension, and lack of dead space and foreign bodies. However, the methods of wound closure and the suture materials have not been universally settled.

Wounds can be classified as follows:

1. Clean wounds, which are not exposed to microorganisms, such as inguinal hernia repair.

2. Potentially contaminated wounds, which are exposed to minimal contamination, such as appendectomy.

3. Grossly contaminated wounds, which are heavily seeded with microorganisms, such as perforated colonic lesions.

Suture Materials

The surgeon must select suture materials for contaminated wound closure capable of maintaining the aponeurotic layers in apposition until firm union occurs, with a minimum of morbidity. This problem can be further divided into forces favoring disruption, and those that favor firm union.

The disrupting forces are the tensions produced by muscular contractions and by distention, such as occurs with intestinal obstruction and vomiting. The forces generated by voluntary muscles are greater than many realize. For example, the quadriceps femoris in a strong man can produce a tension of 600 kg. (1300 lbs.). Even though the abdominal muscles are thinner, they too develop high tensions such as intra-abdominal pressure of over 100mm. Hg. during coughing.[1]

Opposing the forces favoring wound disruption are those conditions that favor firm union. In the early post-operative period, we believe that the choice of suture material and the technique of closure are important. Certain characteristics of suture materials are significant, *e.g.*, fine, strong sutures, such as 000 steel wire, cut through tissue more rapidly than heavier sutures, whereas, heavier materials, such as 30 linen, will cut out before breaking. Fine sutures such as 0000 catgut break at low tensions; tightly tied sutures cut out at lower tensions than those which just approximate the tissues. Mattress sutures hold better than simple sutures, but subfascial stay sutures are ineffectual in holding the fascial layers together.

The type of suture material plays a major role in proper wound closure. Catgut has the great advantage of absorbability, which precludes chronic sinuses. The catgut closure of peritoneal and fascial layers probably remains the commonest type of closure throughout the

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world today. A disadvantage of catgut and the chemicals used in its preparation is the intense inflammatory reaction which results and slows wound healing. The rate of absorption of catgut varies and is unpredictable; absorption may occur within several days of repair. Another disadvantage is the reaction caused by the absorbing catgut which disrupts the normal protective body mechanism against multiplying organisms that may have entered the wound. The incidence of wound infection decreases when nonabsorbable sutures replace catgut in wound repairs.

Nonabsorbable suture material includes silk, cotton, nylon, dacron, with or without Teflon coverage, stainless steel, and polypropylene. Each of these has distinct characteristics. Silk loses its tensile strength rapidly—40 percent in one month and 80 percent in three months; the rate varies greatly and the fiber may be intact after two years. Cotton behaves like silk early in the healing process, but does not disappear. Separation of the individual cotton fibers of the suture sometimes produces a comparatively massive histiocystic reaction. Nylon causes little tissue reaction but shows a moderate decrease in tensile strength after several months, whereas dacron maintains tensile strength but causes a moderate tissue reaction. Braided dacron, whether coated with Teflon or not, behaves as a multifilament suture, which perpetuates infection more readily than monofilament sutures. Stainless steel maintains tensile strength and behaves well in infected wounds, but requires special technique in handling; it may later fracture, migrate or cause tissue irritation. Polypropylene, which behaves as a monofilament suture, is strong and smooth and goes through tissues easily. It requires additional knots, which must be carefully tied.[2]

Histological studies of tissue repair reveal that healing time of wounds may be divided into various phases:

1. The lag phase, from day zero to day five.

2. The phase of fibroplasia, from day five to day fourteen.

3. The phase of maturation, from day fourteen until the wound is fully healed.

During the first period there is softening of the tissues caused by the release of cellular enzymes, and accumulation of hexosamine and mucopolysaccharides. Traumatic hyperemia, characterized by local vasodilation, increased capillary permeability, exudation, and infiltration by leukocytes are also present. During this period, the wound is entirely dependent upon the suture material for support and has no intrinsic strength.

The second period begins with the appearance of the fibroblast, and the production of collagen. Hydroxyproline, concurrent with collagen formation, begins to rise rapidly from the fifth to the fourteenth day. From the sixth day onward, the tensile strength increases rapidly as fibroplasia progresses to collagen formation.

The phase of maturation gradually begins after the second week and continues until bonding is complete. This results from the intramolecular and extramolecular bonding of collagen and may last for a year. Tendons and aponeuroses take longer, however, probably because of lack of blood supply.

Keeping these facts in mind, the importance of maintaining tensile strength for more than a couple of weeks is clear and thus it seems unwise to repair wounds with materials that do not reliably maintain tissue tension until healing is complete. The loss of support in poorly healed wounds frequently leads to wound dehiscence and incisional hernias. This is often seen in wounds repaired with catgut as contrasted with those closed with non-absorbable materials.

Technique of Wound Closure

The technique of closure also bears close examination. Mass closure with nonabsorbable materials gives equal or better results than "layer closure" with fine silk or catgut; it also reduces operating time. Through-and-through sutures of an abdominal wound have the

disadvantage of closing relatively avascular skin and subcutaneous tissue, which are most prone to infection. These sutures may also cause ugly scars, especially in obese patients, as they will cut through the fat and allow the deeper tissues to disrupt.

Figure-of-eight sutures of the musculo-aponeurotic layer have the advantage of approximating the essential strong, holding elements of a wound, while the skin and subcutaneous layer are left open for delayed closure at a time when the risk of abscess is at a minimum. Based on sound principles, removable sutures have been advocated as the ideal method of closing wounds but the technique required is considerably more complicated and therefore has not acquired general use.

Wound complications following emergency and elective procedures on the gastrointestinal and biliary tracts continue to represent a major source of postoperative morbidity for the patient and a distressing area of concern for the surgeon. Mendoza,[3] *et al.*, reported a wound infection rate of 20 percent for abdominal cancer surgery at Roswell Park Memorial Institute. Alexander and Prudden[4] stated that the overall wound infection rate at Presbyterian Hospital in New York was 4.2 percent, a figure which included a much wider range of procedures than those being considered here; it would be much higher if just gastrointestinal and biliary cases were tabulated. Grosfeld and Solit[5] reported a 34 percent wound infection rate in cases of perforated appendicitis in which the skin was closed. In analyzing 200 wound disruptions, Alexander and Prudden[6] found that 14 percent of them were infected and another 17 percent had been associated with hematomas. In younger patients, both rates were higher so the authors concluded that "it seems highly probable that technical and therefore preventable factors were responsible for most of the wound disasters in these young patients."

Various approaches have been used in an attempt to cut down on the incidence of wound infections. Herter[7] summarized concisely the pros and cons of mechanical and antibiotic preparation of the bowel for surgery and reported a 13 percent wound infection rate despite these measures. Topical antibiotics have been reported to decrease markedly the incidence of wound infection in colorectal surgery[8] and the use of monofilament suture material[9] has previously been reported to be superior to multifilament material. The experiences of military surgeons in Southeast Asia made it clear that primary skin closure may be quite detrimental to wound healing, so the practice of so-called "delayed primary closure" became an accepted part of total patient care for the gravely wounded soldier.

Extensive clinical experience with subfascial stay sutures as well as through-and-through closures of the abdominal wall produced an unacceptable incidence of wound sepsis, wound disruption, and incisional hernias. For these reasons, use of Teflon-coated dacron was tried when these synthetic sutures became available. Again, the multifilament sutures proved unsatisfactory in infected wounds and resulted in many early and delayed abscesses and granuloma formations.

Use of monofilament synthetic suture for one layer closure of contaminated wounds was suggested by Marks[10] and employed experimentally in the Jefferson Medical College Service at Philadelphia General Hospital for several months prior to this clinical trial.

Experience with Delayed Primary Closure

During the period from June, 1970 to June, 1972, the authors used the technique of closing all their contaminated wounds with fascial figure-of-eight polypropylene sutures and delayed primary closure of the skin. Closure of the skin was usually done with paper tape on the fifth day, but occasionally had to be delayed for as long as 14 to 17 days because of lingering wound sepsis. At times, in obese patients where taping was impractical because of laxity of the tissues and/or skin irritation, closure of the skin with non-absorbable sutures under infiltration anesthesia was performed.

Polypropylene sutures, size 0, were used for closure of the strong musculo-aponeurotic layer. This suture proved malleable enough to hold knots firmly, yet stronger than silk or cotton; it evoked a type of response associated with non-irritant foreign bodies, maintained tensile strength, and remained intact. The anterior and posterior rectus sheaths, along with the peritoneum, were closed with interrupted figure-of-eight polypropylene sutures, or the anterior rectus sheath was closed with polypropylene, after the peritoneum and posterior rectus sheath had been closed with running 2-0 chromic catgut doubled. The total lack of foreign body tissue reaction with polypropylene was well worth the extra time spent placing 2 or 3 throws on the first knot to prevent slippage, and the extra bulk created by an additional 4 or 5 knots to avoid subsequent untying. Using this technique, the skin and subcutaneous space were left open, lined with a porous, non-adherent gauze and packed open with povidone-iodine soaked gauze. All this was covered by a standard dry dressing and held in place with Montgomery straps.

The timing of the delayed closure was clinically individualized according to the degree of inflammatory reaction, and, in general, was accomplished on the fifth day with tincture of Benzoin and paper strips. Granulations had progressed rapidly by this time and the deep blue knots of polypropylene were no longer visable at the time of closure. The strips were usually removed on the patient's first post-operative visit, about 10 to 12 days after their application. Occasionally, strips had to be changed, but this was infrequent. All discharging wounds were cultured and generally the organisms coincided with the original culture done at operation.

All patients who had potentially contaminated wounds such as bowel anastomosis or choledocholithotomy, and those who had grossly contaminated wounds as occur following visceral perforations, received parenteral antibiotic drugs preoperatively in time to have a therapeutic level of these drugs during the operation. Antibiotics were continued in the post-operative period for three days unless clinical indications required longer therapy. Appropriate changes in antibiotic therapy were based on the sensitivity reports of the operative cultures. The drugs of first choice were penicillin, tetracycline, and streptomycin, with sodium cephalothin and kanamycin sulfate second choice. Postoperative dosages for average adult patients were 5 million units of aqueous sodium penicillin G and 500 mgs of tetracycline hydrochloride intravenously and one gram of streptomycin sulfate intramuscularly. Alternatively, 2 grams of sodium cephalothin and 500 mgs of kanamycin sulfate were administered intravenously. Appropriate changes in doses were made according to the usual clinical indications of age, weight, and state of disease. In addition, patients having elective colon resections had mechanical bowel preparation, which consisted of a clear liquid diet, daily enemas, and daily saline laxatives for two days. Castor oil was given the afternoon prior to the operation. A forty-eight hour schedule of oral kanamycin was administered by giving one gram hourly for four doses and then one gram every six hours. A similar preparation was used in operations for esophageal and gastrointestinal malignancies.

This technique of handling contaminated wounds was used in 80 colon resections, 34 small bowel resections, and 42 gastric resections. All left colon resections with anastomoses or Hartman resections were drained with soft Penrose drains; low anterior colon resections with anastomoses below the peritoneal reflection were drained with sump suction. A culture of gastrointestinal contents was taken in every case. During this period, 259 biliary tract procedures were performed, including 75 procedures on the common bile duct. A transverse upper abdominal incision was used in almost all cases with complete division of the right rectus muscle and linea alba. We used polypropylene exclusively on the anterior rectus fascia and linea alba in closing these wounds. Biliary cultures which were taken routinely in every case were positive in 20 percent of cases. Despite this figure, we usually closed the skin in biliary cases and yet had a wound infection rate of only 2.3

percent and, happily, had only 3 sinus tracts; these eventually cleared after removing a polypropylene suture. Delayed primary closure was used on patients with frank empyema of the gall bladder.

A two-year clinical experience with monofilament polypropylene in all phases of potentially contaminated and grossly infected surgical wounds has shown that this material, when used in conjunction with the technique of delayed primary wound closure, results in excellent fascial healing. A complete absence of wound abscess formation and a minimal problem of sinus formation, requiring subsequent suture removal, were among the added benefits of this new method. There was one case of wound dehiscence of an upper abdominal midline fascial closure in an aged emaciated patient with peritonitis and chronic bronchitis. This was thought to be a partially technical error as figure of eight sutures were not used.

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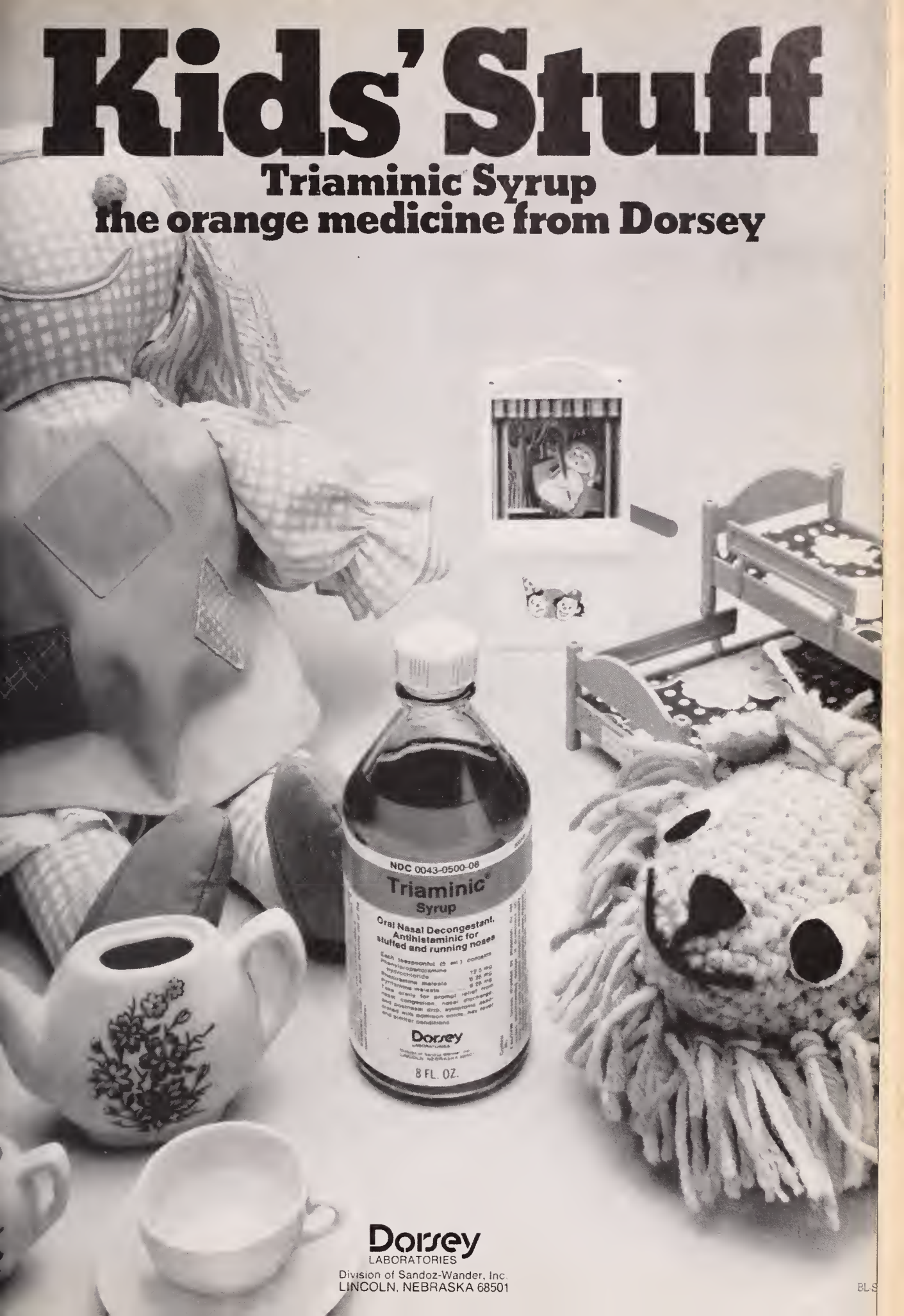

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1. *Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.*

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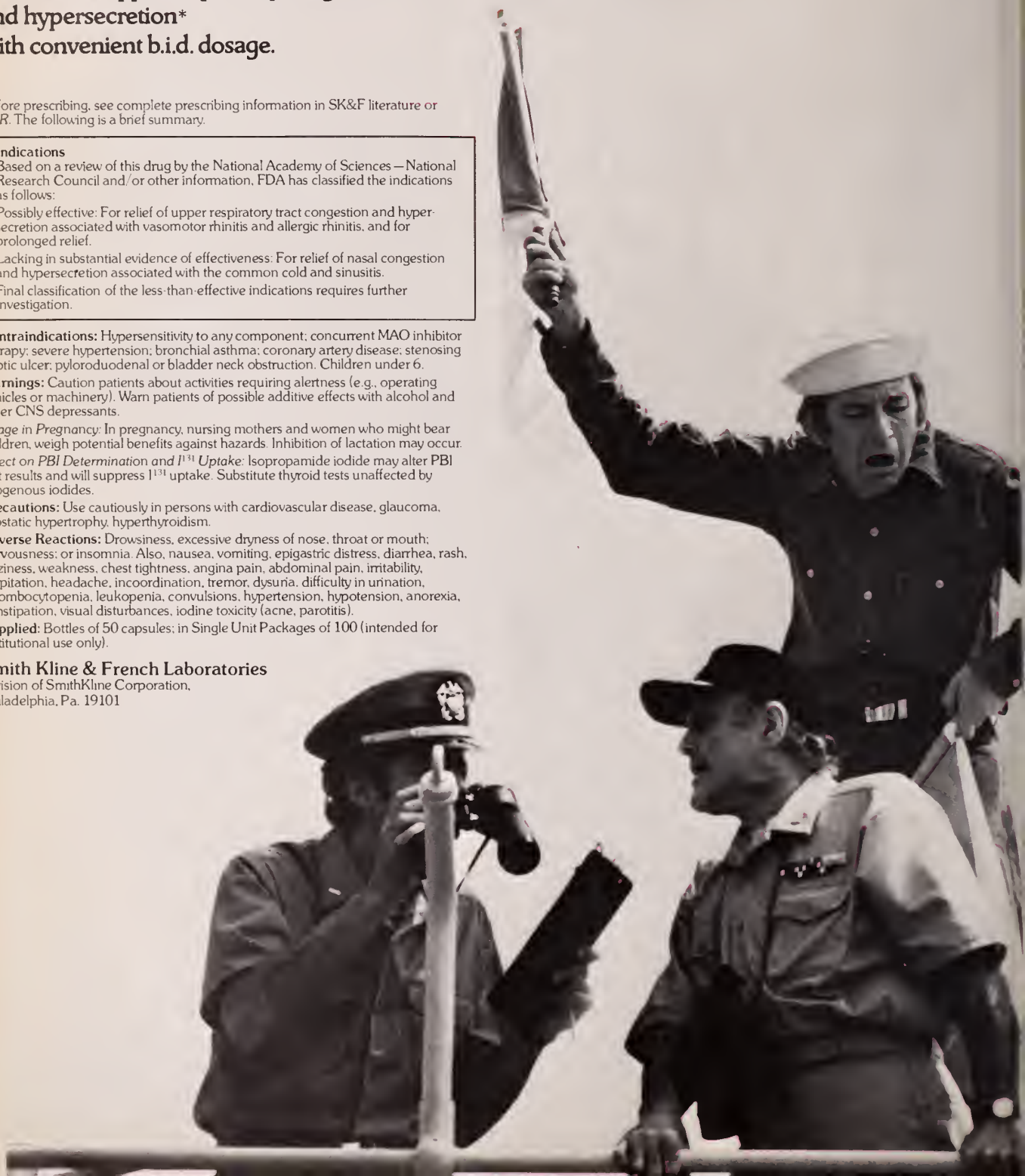

All patients admitted to CCU during a one-year period were studied for evidence of digitoxicity. Twenty-eight per cent of our digitalized patients were toxic according to previously established criteria. In general, digitoxic patients took diuretics more often, had more advanced heart disease, and significantly more azotemia, hypoxemia, and metabolic alkalemia than nontoxic subjects. The more commonly encountered digitoxic arrhythmias were of supraventricular origin, notably NPJT and PAT with varying degrees of AV block. A probability table is presented for the differentiation of digitoxic from nondigitoxic arrhythmias and conduction defects.

Digitoxic Arrhythmias: 1974*

E. L. Rothfeld, M.D., V. Parsonnet, M.D., I. R. Zucker, M.D., D. Rothfeld, M.D., D. M. Voorman, R.N., and B. M. Graves, R.N./Newark

There is considerable evidence that the prevalance of iatrogenic arrhythmias has increased markedly in the past decade, undoubtedly related to the advent of the modern CCU with its emphasis on aggressive therapy, often administered in a "cookbook" fashion. While many pharmacological agents and electromechanical devices have contributed to the overall problem, the most common and the most serious offenders are the digitalis glycosides. Yet, the diagnosis of digitalis toxicity remains enigmatic because digitoxic arrhythmias and conduction defects are extremely variable, and because the noncardiac manifestations of toxicity have little or no specificity. We evaluated all patients admitted to our CCU during a 12-month period, retrospectively, in an effort to describe our spectrum of digitoxic arrhythmias and to define its electrocardiographic and clinical features. We hoped to establish guidelines for resolving a venerable clinical conundrum, "Too much dig or not enough?"

Material and Methods

We studied consecutive patients admitted to Newark Beth Israel Medical Center CCU from January 1st to December 31, 1973 and determined whether they were taking a digitalis preparation by direct questioning, from outpatient charts, nursing home records or attending physician's files. We also recorded other medications and inquired about possible digitoxic symptoms including nausea, vomiting, visual disturbances and confusion. All patients were classified, functionally, according to the criteria of the New York Heart Association.[1] Standard 12-lead electrocardiograms were taken at least once daily and rhythm strips were available at hourly intervals. Routine laboratory data including hemograms, SMA-12 determinations, arterial blood gases and serum electrolytes were obtained at least once in each patient. Radioimmunoassays for digoxin and digitoxin were performed in 36 patients by methods previously described.[2] Patients were categorized as digitoxic or nontoxic according to the criteria of Beller, *et al.*[3]

Results

Of 842 consecutive patients admitted to the CCU between January 1st and December 31, 1973, 269 (32 percent) were taking either digoxin or digitoxin and 74 (28 percent) of the digitalized patients fulfilled the criteria for digitoxicity.

The clinical data for digitoxic and nontoxic patients are listed in Table One. They are quite similar excepting that digitoxic patents were taking diuretics more often and had more advanced heart disease as defined by functional classification.

The laboratory data are listed in Table Two. These are also similar for digitoxic and nontoxic patients except for the significantly

*From the Critical Cardiac Unit, Newark Beth Israel Medical Center. This study was supported, in part, by a grant from the New Jersey Heart Association.

higher prevalence of azotemia, hypoxemia and metabolic alkalemia in the digitoxic group. The mean serum levels for digoxin and digitoxin were higher in toxic patients than in nontoxic ones, but there was considerable overlap and radioimmunoassays were available in only 36 cases.

The digitoxic arrhythmias are listed in Table Three. Supraventricular arrhythmias were the most common, occurring in 42 cases or 57 percent of the digitoxic group; nonparoxysmal junctional tachycardia (NPJT) was detected in 26 patients and paroxysmal atrial tachycardia (PAT) with varying degrees of atrio-ventricular (AV) block was observed in 12. Ventricular arrhythmias were seen in only 17 instances or 23 percent of the digitoxic group; these consisted of uniform and multiform premature systoles, bifocal accelerated idioventricular rhythm (AIVR) and paroxysmal ventricular tachycardia (PVT) with and without exit block. Digitoxic conduction defects included sino-atrial (SA) block with and without Wenckebach episodes in six patients, eight examples of Type I (Wenckebach) incomplete AV block, and three instances of suprahisian and one of infrahisian complete AV block. Five patients had coexisting double tachycardias. Conspicuous by their absence were atrial flutter and fibrillation, Type II (Mobitz) incomplete AV block and intraventricular fascicular conduction defects.

Discussion

Despite the limitations of retrospective analysis, it seems reasonably clear that digitalis toxicity occurs commonly in our CCU and that its prevalance may actually be rising here and elsewhere.[4] More than one-fourth of our digitalized patients were toxic, and this finding is consistent with the results of other contemporary reports.[3,4] Whether the increased frequency is due to more aggressive use of digitalis and kaliopenic diuretics, a larger number of older, sicker patients, or to better methods of arrhythmia detection remains conjectural.[4] Furthermore, our data confirm the impression that there has been a remarkable change in the spectrum of digitoxic arrhythmias, a concept that has sparked considerable interest in recent publications.[3,4,5]

Clinical Data: Inspection of Table One shows that digitoxic and nontoxic patients were similar except that the former were taking diuretics significantly more often and had more advanced heart disease as defined by New York Heart Association functional classification. There were no significant differences in mean age, sex, type of digitalis preparation or presence of noncardiac symptoms such as nausea, visual disturbances and confusion. Our clinical findings are supported by some comparable studies[3] and are refuted by others.[6]

Table 1

Clinical Data

		Toxic Patients	*Nontoxic Patients*	*p Value*
Total number		74	195	
Mean age		71	68	NS
Sex		41 Female 33 Male	106 Female 89 Male	NS
Digitalis preparation	Digoxin	68	184	NS
	Digitoxin	6	11	NS
Diuretics		62	91	<0.05
Symptoms	Nausea or vomiting	48	82	NS
	Visual disturbance	4	6	NS
	Confusion	18	39	NS
NYHA classification	I or II	11	123	<0.001
	III or IV	63	72	<0.001

Laboratory Data: Table 2 indicates that digitoxic patients had significantly more azotemia, hypoxemia and metabolic alkalemia than the nontoxic group, but that the remaining SMA-12 determinations, the serum electrolytes and the hemograms were similar in both groups. We were mildly surprised that hypokalemia was not more prevalent in the digitoxic pa-

Table 2

Laboratory Data

		Toxic Patients (mean values)	*Nontoxic Patients (mean-values)*	p Value
Hemogram	Hematocrit	41	43	NS
	WBC/cu mm	5410	5628	NS
	Platelets/cu mm	242×10^3	218×10^3	NS
SMA 12	Total Protein (Gm/100 ml)	5.8	6.1	NS
	Albumin (Gm/100 ml)	3.6	3.8	NS
	Calcium (mg/100 ml)	9.8	10.1	NS
	Inorganic phosphorus (mg/100 ml)	3.2	3.4	NS
	Cholesterol (mg/100 ml)	242	258	NS
	Glucose (mg/100 ml)	108	114	NS
	Urea nitrogen (mg/100 ml)	48	29	<0.01
	Uric acid (mg/100 ml)	7.1	5.8	NS
	Creatinine (mg/100 ml)	1.2	0.9	NS
	Bilirubin (mg/100 ml)	1.1	0.8	NS
	Alkaline phosphatase (I.U./ml)	62	54	NS
	SGOT (I.U./ml)	48	51	NS
Serum Electrolytes	Sodium (mEq/L)	134	136	NS
	Potassium (mEq/L)	3.4	3.9	NS
	Chloride (mEq/L)	92	96	NS
Arterial Bloodgases	pH	7.48	7.39	<0.05
	pCO_2 (mm Hg)	42	36	NS
	pO_2 (mm Hg)	56	71	<0.05
	HCO_3 (mEq/L)	34	22	<0.05
Radioimmunoassay	Digoxin (n/ml)	2.1	0.9	<0.01
	Digitoxin (mg/ml)	32	19	<0.001

tients. Again, review of the literature disclosed investigations that both confirm[7] and deny our laboratory data. We can draw no conclusions from the radioimmunoassays for digoxin and digitoxin because this information was available in only 36 patients and because there was considerable overlap between toxic and nontoxic cases. While most reports have shown significantly higher levels in toxic than in nontoxic patients,[2,7] we agree with those who argue that the diagnosis of digitalis toxicity cannot be made from this test alone, and that the radioimmunoassay must be considered within the overall clinical picture.[3]

Digitoxic Arrhythmias: Supraventricular arrhythmias, especially NPJT and PAT with AV block, were the most common digitoxic arrhythmias in our series (Table 3); this finding is consistent with recent publications,[3,7] but is very different from observations described in the older literature.[8,9] We have the impression that the alleged change in the spectrum of digitoxic arrhythmias is related more to constant monitoring of the electro-

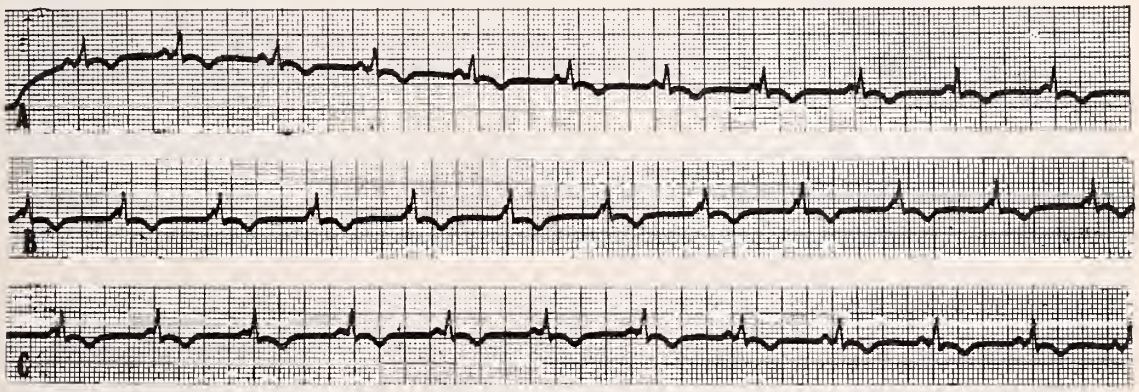

Figure 1—Strips A, B and C are a continuous recording of lead II. Nonparoxysmal junctional tachycardia (NPJT) with a rate of 78/min. is competing with normal sinus rhythm (NSR), rate of 76/min. The similarity of the rates produces isorhythmic dissociation and imitates simple NSR. NPJT is the most common manifestation of digitoxicity in our series.

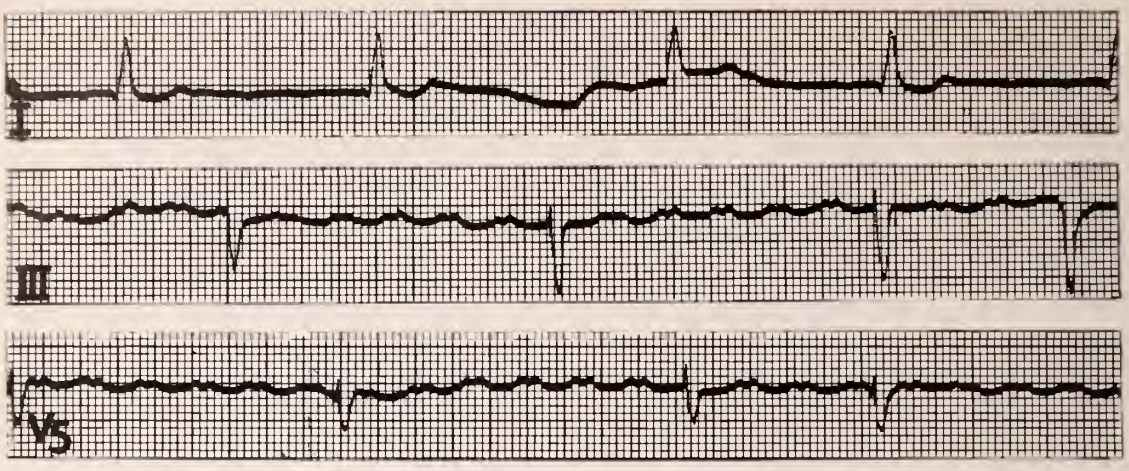

Figure 2—Leads I, III and V_5 belong to the same patient; they indicate PAT with high/grade AV block. This arrhythmia is virtually pathognomonic of digitoxicity.

cardiogram and improving physician awareness and education than to an actual alteration in these arrhythmias. For example, NPJT may have been overlooked in the past because the rates of the sinus and junctional pacemakers can be similar, leading to isorhythmic dissociation, an entity that mimics normal sinus rhythm and is distinguished from it only by subtle changes in PR interval (Figure 1). NPJT may also arise in the setting of atrial fibrillation, thereby subtly converting an irregular to a regular response; patients with atrial fibrillation and regular ventricular rates are nearly always digitoxic and failure to recognize this dictum may invite disaster. PAT with AV block is suggestive, but not diagnostic of digitoxicity. However, the probability of digitoxic PAT rises as the degree of AV block increases (Figure 2). Less commonly seen digitoxic supraventricular arrhythmias include sinus premature systoles and non-respiratory sinus arrhythmia.

In our series, ventricular arrhythmias occurred less often than expected, and contrary to the older literature, these arrhythmias made up a relatively small percentage of the entire group. Multiform ventricular arrhythmias were more specific for digitoxicity, but they occurred less often than the uniform variety (Figure 3). PVT with exit block is another uncommon, but relatively specific digitoxic arrhythmia.

Table 3
Digitoxic Arrhythmias

Rhythm	*No. of Patients*
Supraventricular	*42*
Nonparoxysmal junctional tachycardia	26
Paroxysmal atrial tachycardia with varying AV block	12
Non-respiratory sinus arrhythmia	3
Sinus premature systoles	1
Ventricular	*17*
Premature systoles, uniform and multiform	12
Bifocal accelerated idioventricular rhythm	2
Paroxysmal ventricular tachycardia, with and without exit block	3
Conduction defects	*18*
SA block, varying degrees	6
Type I, second degree AV block	8
Complete AV block (supra- and infrahisian)	4
Double tachycardias	*5*

The most frequent digitoxic conduction defects were Type I second degree AV block (Figure 4), suprahisian complete heart block (Figure 5) and SA block with and without Wenckebach sequences. Notably absent among digitoxic conduction defects in our evaluation and that of others were Type II (Mobitz) second degree AV block and the intraventricular fascicular blocks. [3,7]

Double tachycardias, present in five of our patients, are nearly always digitoxic in origin (Figure 6). Coexisting atrial and ventricular tachycardia or NPJT plus AIVR should always serve to resurrect the ogre of digitoxicity.[10,11]

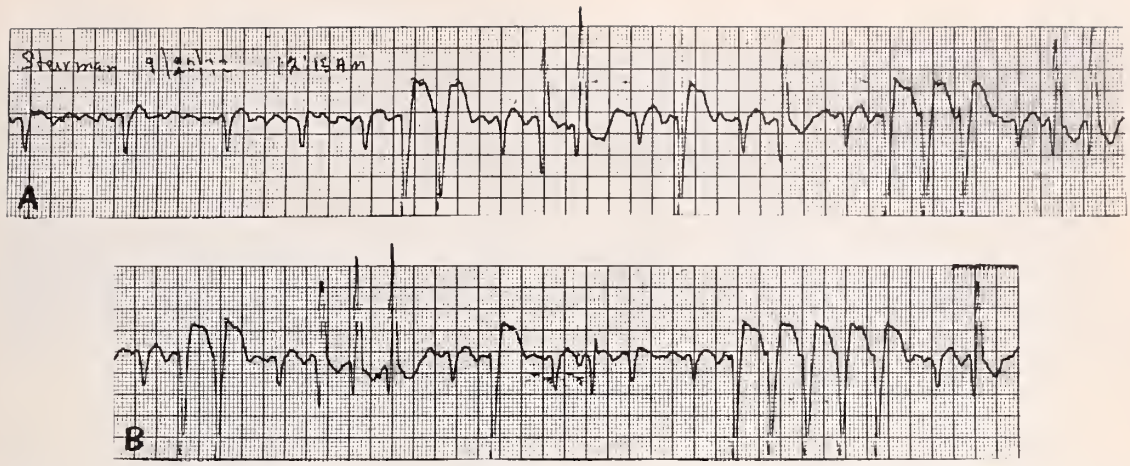

Figure 3—Strips A and B show multiform ventricular premature systoles that are frequently, but not always due to digitoxicity.

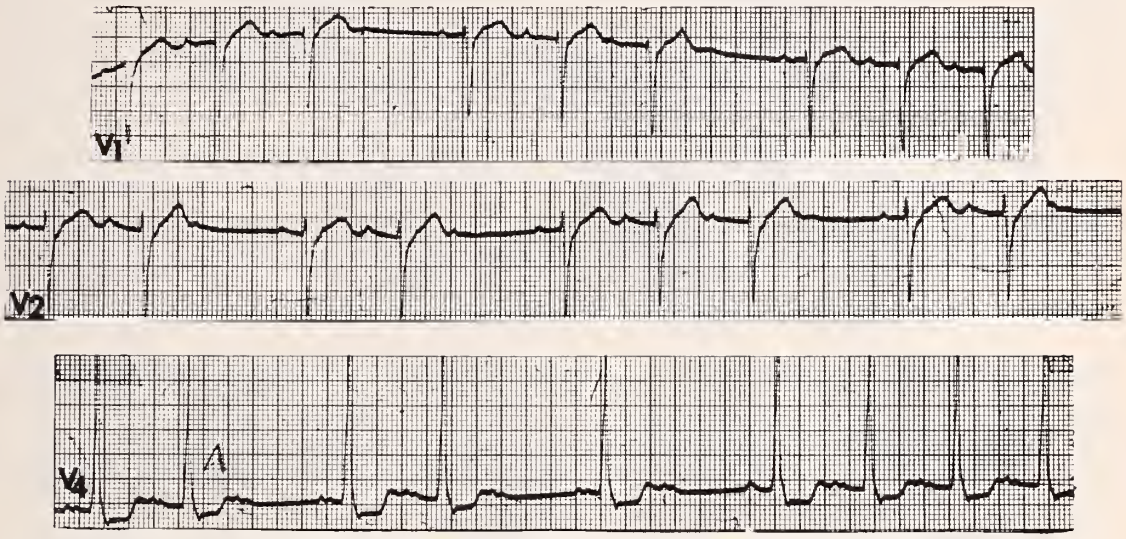

Figure 4—V1, V2 and V4 show classical Type I (Wenckebach) second degree AV block, a common manifestation of digitoxicity.

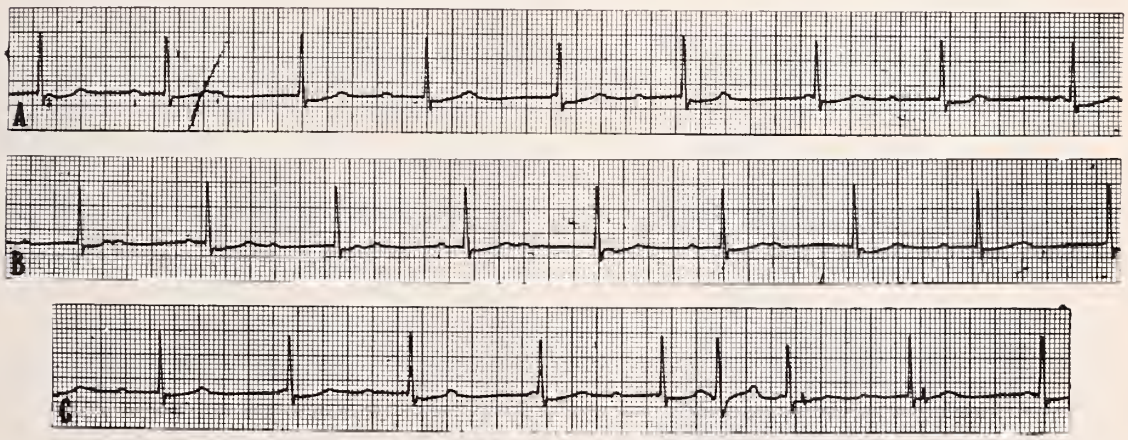

Figure 5—Strips A, B and C are a continuous recording of complete heart block with an atrial rate of 92/min. and a ventricular rate of 60/min. The narrow QRS contour indicates that the block is suprahisian, i.e., above the AV junction. In digitoxicity, suprahisian conduction defects occur more often than the infrahisian variety.

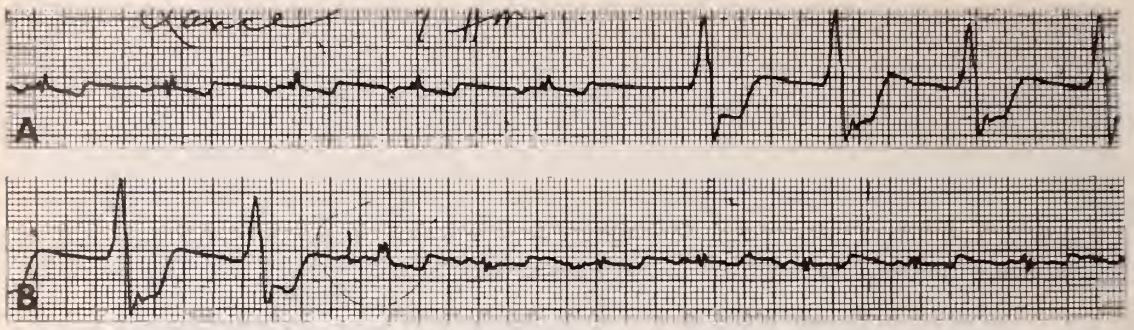

Figure 6—The first five beats in strip A constitute NPJT, while the last four beats in A plus the first two beats in strip B represent AIVR. The double tachycardia is a rare, but specific manifestation of digitoxicity.

Table Four represents a schema for the identification of digitoxic arrhythmias based on our data and that gleaned from recent publications. The major arrhythmias and conduction defects are arranged in three groups: those that are common manifestations of digitoxicity; those that occur less often, but are very suggestive of digitoxicity; and those that are almost never due to digitalis. Hopefully, this probability table will be of value to the clinician who must cope with the perennial dilemma of "Too much dig or not enough."

Table 4
Digitoxic Arrhythmias

Common

1. PAT with AV Block (preferably high-grade)
2. Nonparoxysmal junctional tachycardia (with NSR or atrial fibrillation)
3. Multiform and uniform VPCs
4. SA block, complete and incomplete (with and without Wenckebach sequences)
5. Type I (Wenckebach) second degree AV block

Uncommon, but Suggestive

1. Sinus premature systoles
2. Non-respiratory sinus arrhythmia
3. PVT with exit block
4. Bidirectional PVT
5. Multiform accelerated idioventricular rhythm
6. Double tachycardias
7. Suprahisian complete heart block

Rare or Never

1. Atrial flutter
2. Atrial fibrillation
3. Respiratory sinus arrhythmia
4. Type II (Mobitz) second degree AV block
5. Intraventricular trifascicular blocks

Summary

All patients admitted to CCU *during a one-year period* were studied for evidence of digitoxicity. Twenty-eight percent of our digitalized patients were toxic according to previously established criteria. In general, digitoxic patients took diuretics more often, had more advanced heart disease and significantly more azotemia, hypoxemia and metabolic alkalemia than nontoxic subjects. The most commonly encountered digitoxic arrhythmias were of supraventricular origin, notably NPJT and PAT with varying degrees of AV block. A probability table is presented for the differentiation of digitoxic from nondigitoxic arrhythmias and conduction defects.

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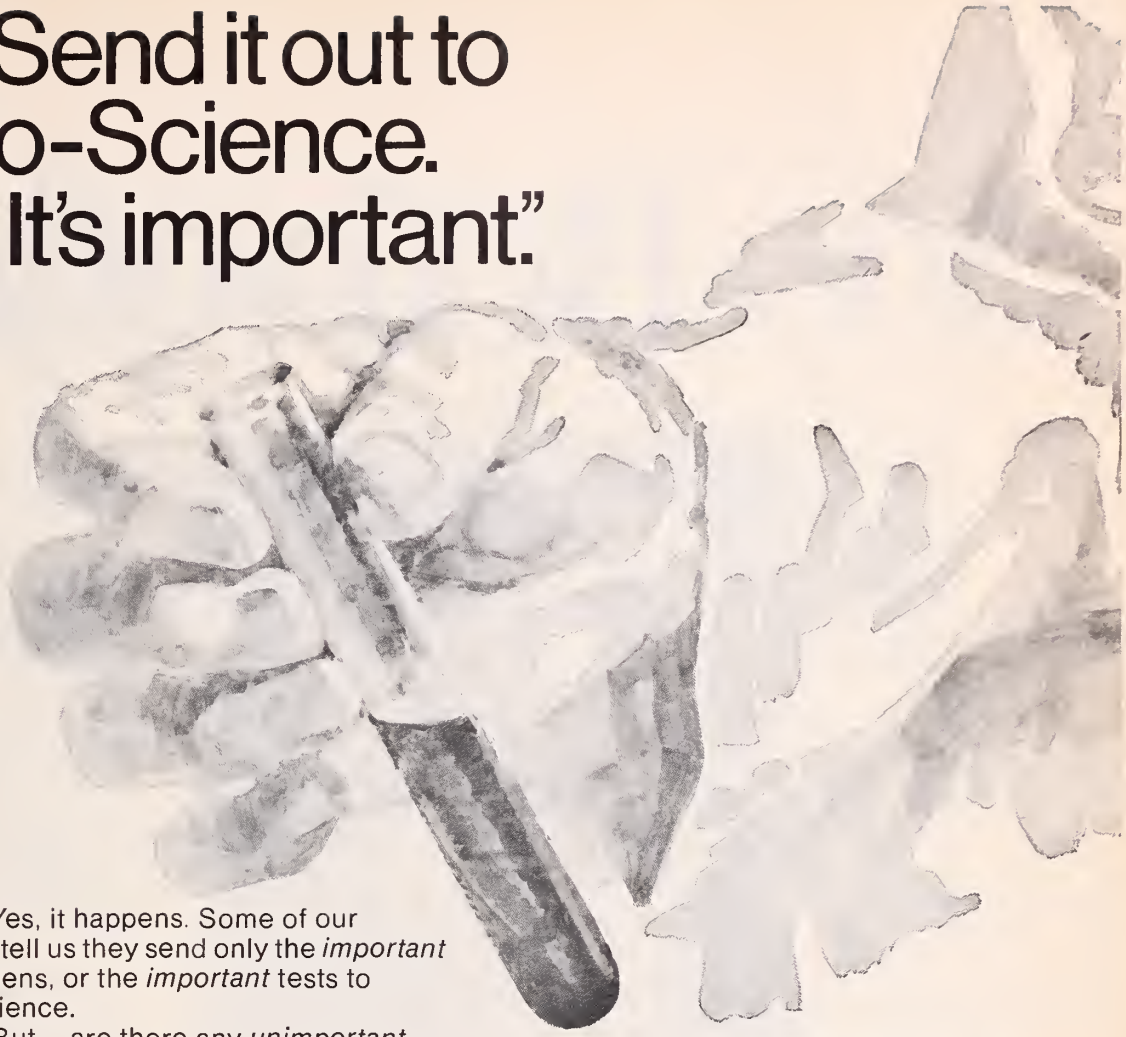

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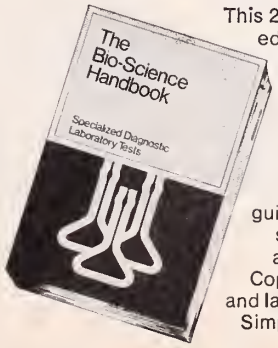

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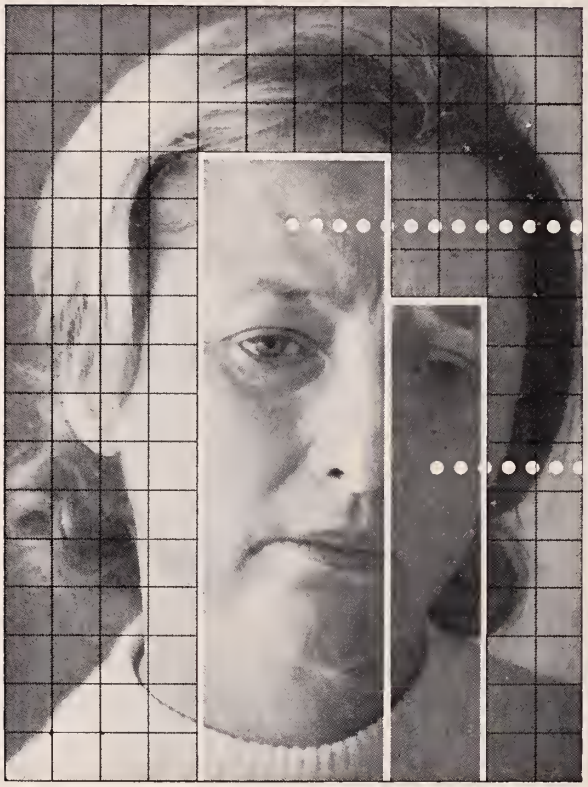

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respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Automated sequential multiple blood chemical analyses are commonly used as a basis for multiphasic screening programs. Despite the use of fasting blood samples, hyperglycemia is the most common abnormality discovered. Prefeeding the screenee with glucose will enhance the sensitivity of the procedure as a diabetes detection method without materially disturbing the other parameters tested. The validity of the procedure may be enhanced by a concomitant chemical analysis for interpretation of LDH, SGOT, and inorganic phosphorus, should they be abnormal.

Enhancing the Sensitivity of the SMA Profile

Arthur Krosnick, M.D./Trenton*

It has been clearly established that the blood glucose determination made in the fasting state is less sensitive as a screening technique than the single postprandial or postglucose test or the standard oral glucose tolerance test. In recent years, the ready availability of inexpensive automated multiple blood chemical determinations has burst on the scene as the foundation for many multiphasic screening programs in industry, health maintenance organizations, community disease screening programs, hospitals, and physicians' offices.

Despite the fact that this type of test is performed on fasting blood samples, an elevated blood glucose value remains the most frequent abnormality in the series. In this regard, the effect of preloading the patient with glucose on the screening integrity of the remaining test parameters is of interest.

Procedure

One hundred sixteen (116) employees of the State of New Jersey volunteered for the study; 88 were female and 28 were male, the majority (102) were in the age range 25 to 64; 11 were under 25 and 2 were 65 or older.

All participants completed a personal health questionnaire, which included a list of all medications being taken at the time of the study. There were 79 individuals (68.1 per cent) who were taking many medications, (prescribed or "over-the-counter" drugs), ranging from anticoagulants to vitamins. No attempt was made to correlate individual drugs with the findings.

Six persons disclosed a history of liver disease, but none of the participants was known to have diabetes at the time of the test.

The procedure required each volunteer to fast overnight, at least 10 hours, but ordinary diet and regular medications were continued through the day prior to the test. A blood sample was drawn, followed by ingestion of 100 grams of glucose in a cola-flavored beverage. One hour after the glucose, a second blood sample was obtained; both specimens were exposed to the SMA® 12/60 technique (AutoAnalyzer®, Technicon). The tests included calcium, phosphorus, glucose, blood urea nitrogen, uric acid, cholesterol, total protein, albumin, total bilirubin, alkaline phosphatase, LDH, and SGOT.

Technicians who noted hemolysis recorded this fact on the appropriate specimen record.

Results

The data were analyzed so as to show the percentage of agreement within the stated Technicon ranges of the specimens obtained before and after glucose loading (Table I) and the average deviation by pattern (Table

*Coordinator, Diabetes and Endocrine Program Division of Community Health Services, New Jersey State Department Health

Table I

Percentage of Persons Tested with Results by Pattern, by Blood Chemistry Test—116 New Jersey State Employees

Blood Chemistry	PERCENTAGE (N-N)	(N-A)	(A-N)	(A-A)	Percent Agreement	Percent Disagreement	Total
Calcium	93.8	0.0	4.4	1.8	95.6	4.4	100.0
Phosphate	82.1	0.9	10.7	6.3	88.4	11.6	100.0
Glucose*	—	—	—	—	—	—	—
BUN	73.2	2.7	3.6	20.5	93.7	6.3	100.0
Uric Acid	98.2	0.0	0.9	0.9	99.1	0.9	100.0
Cholesterol	92.0	2.7	0.9	4.4	96.4	3.6	100.0
Total Protein	95.5	0.9	1.8	1.8	97.3	2.7	100.0
Albumin	96.4	0.0	0.9	2.7	99.1	0.9	100.0
Total Bilirubin	94.6	0.0	1.8	3.6	98.2	1.8	100.0
Alk. P'Tase	77.7	8.0	0.9	13.4	91.1	8.9	100.0
LDH	62.5	8.9	14.3	14.3	76.8	23.2	100.0
SGOT	79.5	2.7	9.8	8.0	87.5	12.5	100.0

N-N = Normal in both specimens
N-A = Normal in first, abnormal in second
A-N = Abnormal in first, normal in second
A-A = Abnormal in both specimens

*Glucose values were expected to rise due to the glucose load, so were omitted from this table.

Table II

Average Deviation by Pattern by Blood Chemistry Tests—116 New Jersey State Employees

Blood Chemistry	AVERAGE DEVIATION BY PATTERN (N-N)	(N-A)	(A-N)	(A-A)	Technicon Normal Range
Calcium (mg.%)	0.21	—	0.73	0.03	8.5-10.5
Phosphate (mg.%)	0.29	0.55	0.54	0.13	2.5-4.5
Glucose (mg.%) *	—	—	—	—	65.0-110.0
BUN	0.57	1.00	0.88	0.52	10.0-20.0
Uric Acid (mg.%)	0.16	—	0.35	0.30	2.5-8.0
Cholesterol (mg.%)	11.26	9.00	15.00	10.10	150-300
Total Protein (gm.%)	0.20	0.70	1.05	0.18	6.0-8.0
Albumin (gm.%)	0.11	—	0.10	0.25	3.5-5.0
Total Bilirubin (mg.%)	0.06	—	0.10	0.03	0.15-1.0
Alk. P'Tase (K.A.U.)	4.01	5.44	21.00	2.90	30.0-85.0
LDH (W.U.)	17.40	71.90	98.40	81.80	100.0-225.0
SGOT (K.U.)	2.89	13.50	17.60	17.40	10.0-40.0

N-N = Normal in both specimens
N-A = Normal in first, abnormal in second
A-N = Abnormal in first, normal in second
A-A = Abnormal in both specimens

*Glucose values were expected to rise due to the glucose load, so were omitted from this table.

II). Four patterns were separated: normal values in specimen 1 and 2 (N-N), normal in 1 and abnormal in 2 (N-A), abnormal in 1 and normal in 2 (A-N) and abnormal in 1 and 2 (A-A).

Table I shows a high degree of consistency in the test patterns, ranging from 91.1 to 99.1 percent. Tests included in this range were calcium, urea nitrogen, uric acid, cholesterol, total protein, albumin, total bilirubin and alkaline phosphatase. Phosphate, SGOT and LDH fell below the others with respective agreement percentages of 88.4, 87.5, and 76.8.

Further cross-analysis was made between participants with elevated SGOT as compared to LDH values and vice versa; in addition, the factor of hemolysis was noted. This analysis suggested a movement of SGOT and LDH in the same direction in specimens 1 and 2 in a number of patients with a tendency toward clustering of abnormalities, implying a technical problem. This was reinforced by the corresponding technician's note as to hemolysis. Similar clustering of abnormalities was also noted with phosphate, in relation to hemolyzed specimens. Elimination of the hemolyzed specimens resulted in a degree of consistency in excess of 90 percent for SGOT, LDH, and phosphate.

Table II shows a rather small average deviation, where the test pattern remained stable, when one considers the wide normal range of values, for all determinations except LDH and SGOT. The wide deviation for alkaline phosphatase in the A-N category was based on a single participant and the explanation for this finding is not known.

Discussion

Other than glucose, eight of the remaining eleven parameters measured by the Technicon AutoAnalyzer® showed a high degree of consistency within the stated normal range of values before and one hour after the ingestion of 100 grams of glucose. The variation in inorganic phosphate was to be expected since this substance tends to show a reciprocal relationship to hyperglycemia.

The variations in SGOT, LDH, and phosphate are best explained by hemolysis of the samples. In general, laboratory technicians tend to record gross hemolysis when the blood serum looks pink or reddish, which requires 50 mg. percent or more of free hemoglobin; the normal circulating free hemoglobin is 4 mg. percent. Lesser degrees of hemolysis may affect the SGOT, LDH, and phosphate values and not be noted. Gross visual estimation of hemolysis is obviously a rough index with subjective judgment playing a major role, so it would be more desirable to have a simple objective screening laboratory test for hemolysis in order better to interpret the SMA 12/60 values.

Comparison of SGOT:LDH elevations revealed three patterns of elevation, apparently dependent upon the degree of hemolysis. As one would expect, LDH increases outside the limits of normal range exceeded the increases in SGOT, even with slight hemolysis, presumably because LDH is present in much greater quantities within the red blood cell.

The wide range of so-called "normal" values for each of the parameters in the SMA 12/60 technique makes the true value of such a series obviously that of a screening technique. The AutoAnalyzer® has many of the good features one expects, i.e., ready availability, inexpensiveness and reliability (i.e. reproducibility and accuracy); furthermore, it promotes efficient utilization of paramedical and technical personnel while providing a method for uncovering hitherto undiagnosed, incipient or latent disease.[1] The clinician, however, must carefully resist the temptation to use "screening" tools to replace diagnostic methodology. It is true that biochemical profiles by the AutoAnalyzer® may suggest liver disease, renal disease, diabetes, hyperparathyroidism, and so on, but one is never privileged to make a diagnostic short-cut by avoiding definitive tests to confirm or rule out suspicions aroused by screening tests.

The two hour postprandial oral glucose load blood sugar test has been accepted as the standard screening technique for diabetes, but the one hour test is equally as sensitive, although a bit less specific.[2] The usual cut-off point for the one hour test in our detection programs is 160 mg. percent (true glucose); that is, the level at which an oral glucose tolerance test is indicated. For many practical reasons, we selected the one hour postglucose point to draw the second sample of blood in this study. One hypothetical reason was to reduce the time interval during which the glucose meal might participate in lipid metabolism and thus raise the cholesterol, especially in persons who might chance to have a Type II or IV Hyperlipoproteinemia. It was gratifying to note that the percentage of agreement for cholesterol was high (96.4 percent). A practical reason was to permit the laboratory staff to run the samples through the AutoAnalyzer® early in the morning with their usual fasting specimens.

Conclusions

The feeding of glucose one hour prior to collection of blood for an SMA 12/60 determination will make the glucose test more sensitive without materially disturbing the other eleven parameters. Hemolysis is a major interfering condition for the SGOT, LDH, and inorganic phosphate values. Furthermore, a temporary decrease in serum phosphorus can be expected after an oral glucose load, which increases carbohydrate metabolism.

Since significant but invisible degrees of hemolysis may be present, a method for chemically measuring hemolysis might be of value in enhancing the value of the biochemical profile technique of multiphasic screening.

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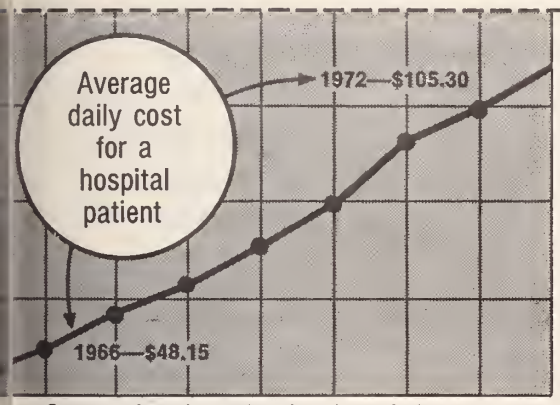

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Elevated environmental noise levels are a largely unrecognized public health problem in New Jersey. Sources of noise pollution and units for its measurement are outlined, as well as detrimental physiological and psychological effects. Strategies for the abatement and control of the noise pollution problem are also discussed.

Detrimental Health Effects of Noise Pollution

John D. Bogden, Ph.D./Newark*

Noise is sound that is unwanted by the listener, either because it is unpleasant or bothersome, interferes with the perception of wanted sound, or is physiologically harmful. Obviously, noise as unwanted sound does not have any particular characteristic to distinguish it from wanted sound. As a heavily industrialized state and the most densely populated state, New Jersey has noise pollution problems as acute as those of any other state in the nation.

There is a tendency to overlook noise as an environmental health hazard because it has a rapid decay time and, unlike most air and water pollutants, remains in the environment only for limited periods of time. In addition, the physiological effects of noise on man are usually subtle and appear gradually over extended periods of time. This has made it difficult to associate cause and effect, again favoring a tendency to ignore the detrimental health effects of noise.

As a pollutant, noise can be considered an energy residual in contrast to the mass residuals such as hydrocarbons or nitrogen oxides in the air and pesticides or insecticides in food and water. (Another type of energy residual is the thermal pollution of streams and rivers from which water is used to cool the reactors of atomic energy plants.) The amount of energy associated with noise is quite small in comparison to other forms of energy. For example, a deafeningly loud (120 decibel) sound represents only about 1/10,000 of a watt of energy.[1] However, the extraordinary ability of the ear to perceive sound permits excessive noise levels to have adverse health effects on man and other biological species.

Measurement

There are two readily measurable physical parameters of sound—its pressure and frequency. Sound actually is comprised of small fluctuations in atmospheric pressure. The ear is capable of detecting the magnitude of these fluctuations (pressure) and the rate at which they occur (frequency).

Sound pressure is measured in decibels. Since the difference between minimum detectable sound pressures and maximum sound pressures generally encountered is very large, it would be awkward to use a linear scale for the description of sound pressure. Therefore, a logarithmic scale is used. If the acoustical energy output for a sound source is doubled, the sound pressure increases by about 3 dB.[2] Thus, 90 dB is approximately twice as loud as 87 dB.

Frequency, usually measured in cycles per second (cps) or Hertz (Hz) (the two are equivalent), is the quality of noise which makes it a clang, bang, or a whistle. The difference between a tuba and piccolo playing the same tune is a frequency difference. The range of human hearing is about 15-20,000 Hz.[3] The human ear is capable of analyzing noise in one-half decibel stages and detecting frequency changes of 2 or 3 Hz.

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However, meters and other instrumentation cannot measure the qualities of noise to which humans respond. We hear "loudness" and "pitch," while meters measure sound pressure levels and frequencies. Loudness depends primarily upon the sound pressure level, but it also depends upon the frequency. Pitch depends primarily upon the sound frequency, but there is also some dependence on the sound pressure level. This type of consideration has led to the development of "scales" which can be used to relate the measurable physical quantities to the subjective qualities such as loudness or noisiness. One scale which correlates well with human responses to noise is the A-scale. This scale gives less emphasis to low frequency sounds and more emphasis to the more annoying and more harmful high-pitched sounds.[4] Most studies of the deleterious effects of noise on humans use A- weighted sound pressures.

Sources

Table 1 contains typical sound pressure levels of various noise sources.[5] In an urbanized area such as northern New Jersey, the primary producers of noise are transportation sources. In a typical urban area, more than half the noise produced will be from automobiles and other motor vehicles and up to 20 percent will be from aircraft.[6] Radios, televisions, construction equipment, and voices are also sources which contribute significantly to the overall noise levels in urban and suburban environments.

Many economic indicators (e.g. number of jet aircraft, energy consumption, motor vehicle registrations) support the idea that ambient noise levels have rapidly increased throughout New Jersey during the last twenty years. In light of this observation, we might expect the detrimental health effects of noise to be more widespread in the future than they are now. In addition, the absence of economic incentives to reduce noise levels, demographic changes causing a larger percentage of the population to be exposed to noise sources (urbanization), and a lack of awareness of the adverse health effects of noise by both health professionals and the general public have contributed to the problem.

Table 1

Sound Pressure Levels of Various Noises

Sound Description	*Decibels*	*Sound Source*
Threshold of Feeling/Pain	120	Rocket engine Turbojet: 7,000 pounds thrust
Deafening	110	Propeller aircraft Nearby riveter Nearby thunder
	100	Jet at 1,000 feet Subway and elevated trains Discotheque
Very Loud	90	Woodsaw, punch press Loud street noises Noisy factory
	80	Pneumatic drill Police whistle, portable sander Power mower at 50 feet
Loud	70	Noisy office Average traffic Normal radio
	60	Average factory Air conditioner at 20 feet
Moderate	50	Noisy home Average office Ordinary conversation
	40	Quiet radio
	30	Quiet home
Faint	20	Quiet conversation
Very Faint—Threshold of Audibility	10	Rustle of leaves Whisper
	0	Soundproof room

Auditory Effects

Noise-induced hearing loss occurs because of exposure to elevated noise levels over long periods of time. It is estimated that four to five million people in the United States have experienced some noise-induced hearing loss.[7] This suggests 160,000 to 200,000 as the approximate number of New Jersey residents who have experienced some noise-induced loss of hearing, and the number is likely to increase dramatically in the absence of increased public awareness and action.

The first noticeable effect of exposure to excessive noise levels is tinnitus—a ringing in the ears accompanied by a temporary loss of hearing (increase in the threshold of hearing).

Given sufficient time, the individual's hearing recovers from these initial symptoms upon removal of the noise source and eventually returns to the pre-exposure state. However, if the exposure is exceptionally long or intense or frequently repeated, a fraction of the temporary hearing loss can become permanent.

The outer ear, eardrum, and middle ear are almost never damaged by exposure to intense noise. The eardrum, however, can be ruptured by extremely intense noises. Experimental work with laboratory animals and autopsies on humans indicate that permanent noise-induced hearing loss results from degeneration of the hair cells in the organ of Corti of the inner ear.[8] The hair cells are biological transducers which convert the mechanical motions of sound into electrical impulses which can be interpreted by the brain. They respond to sound vibrations in a manner analogous to seaweed moving back and forth with rapidly changing ocean currents. The loss of 15 to 20 percent of the cells that respond to high frequencies can reduce hearing sensitivity by up to 40 dB.[9] In addition, once hair cells are destroyed they do not regenerate. Table 2 contains a qualitative description of the hearing loss associated with various threshold shifts.[10]

Table 2

Description of Hearing Loss Associated with Various Threshold Shifts

Degree of Handicap	Average Hearing Threshold Level For 500, 1,000 and 2,000 Hz in the Better Ear: More Than	Not More Than	Ability to Understand Speech
Not significant		25 dB	No significant difficulty with faint speech
Slight Handicap	25 dB	40 dB	Difficulty only with faint speech
Mild Handicap	40 db	55 dB	Frequent difficulty with normal speech
Marked Handicap	55 dB	70 dB	Frequent difficulty with loud speech
Severe Handicap	70 dB	90 dB	Can understand only shouted or amplified speech
Extreme Handicap	90 dB		Usually cannot understand even amplified speech

The threshold shifts induced by exposure to excessive noise levels can have both permanent and temporary components. For example, a threshold shift of 60 dB might consist of a 10 dB permanent shift and a 50 dB temporary shift. Experimental work with animals has suggested that there is generally no additional recovery beyond twelve weeks after cessation of exposure to high noise levels and that threshold shifts remaining after this period of time can be considered permanent.[11]

Most studies of the deleterious effects of noise on humans have been done on individuals working in specific noisy industrial environments. One factor that must be kept in mind is that people differ widely in their susceptibility to noise-induced hearing loss and that the establishment of acceptable environmental noise levels must take individual susceptibility into account. For example, if one takes 35 years as an average (for an 8-hour workday) industrial exposure at an average sound pressure level of 85 dB (A scale), then about 8 percent more people will have hearing impairment (25 dB shift) than with no exposure above 80 dBA.[12] Ninety dBA increases hearing impairment incidence to 17 percent.[12] This type of consideration suggests 85 to 90 dBA as a reasonable hearing conservation criterion. More recent thinking indicates that a more acceptable average daily noise level is 70 dBA.[13]

The changes in hearing produced by excessive exposure to noise include distortions of the clarity and quality of sound as well as an increase in the threshold of hearing. A hearing aid is capable of amplifying sound to make it audible, but it cannot correct for the distortions that often accompany injury to an organ of Corti.

Hearing conservation through effective environmental control of noise is more important because of presbycusis, the normal loss of hearing with increasing age. Any loss due to excessive exposure to noise occurs in addition to

this normal loss. Studies of hearing loss due to exposure to excessive noise must be done in such a way that the effects of presbycusis are taken into consideration.

It should be kept in mind that hearing loss does not occur uniformly at all frequencies. In general, hearing at the higher frequencies (3,000-6,000 Hz) is affected before hearing loss at lower frequencies begins.[14] The AMA recommends the use of the three frequencies of 500, 1,000, and 2,000 Hz for the measurement of hearing impairment. Hearing impairment at these lower frequencies usually means that hearing impairment will also be found at the higher frequencies.

Non-Auditory Effects

Noise also induces various non-auditory physiological and psychological effects in man and animals. The vasoconstriction reflex—a reduction in size of the smaller arteries, an increase in pulse rate, and an increase in respiration rate—is found upon exposure of humans to the relatively low noise level of 70 dBA.[15] However, there is no conclusive data to support the existence of any related permanent effects.

There are varying degrees of evidence to support theories that noise produces fatigue, dizziness, and loss of balance and that it also affects sleep patterns and may, therefore, affect the recovery rate from illness.[16] The psychological and sociological effects of noise include annoying interference with speech, mental stress, fatigue, and a diminished ability to perform physical and mental tasks.

Some European research has indicated that there are correlations between health (e.g. cardiovascular irregularities) and exposure to intense occupational noise.[17] A Russian study found that adults living near airports had higher than expected morbidity rates, but noise as a cause could not be unequivocally established.[17] In this regard, present regulations prohibiting planes leaving or landing at Newark airport from flying over the city of Elizabeth seem wise.

There is also evidence that the fetus is capable of perceiving sounds and responding to them "in utero" by increased motor activity and cardiac rate change.[18] The role of noise in the hospital environment has also been the subject of recent speculation concerning possible adverse effects on both patient recovery and hospital staff performance.[19] Several New Jersey hospitals which I have visited have noise levels which are decidedly annoying and distracting. However, the non-auditory effects of noise have not been adequately investigated, and more research is needed to firmly establish the precise nature of these effects.

Abatement and Control

The minimizing of the adverse health effects of noise can be accomplished by such obvious measures as removal of noise sources, acoustic shielding and decreasing the time of exposure. Ear protection devices are also useful. However, in spite of the effectiveness of earplugs and earmuffs, people will often decline to use them for reasons of appearance, discomfort, or nuisance.

Land-use planning (environmental engineering and biotechnology) can also serve to locate noise-producing sources at a distance from locations where people will be living or working. The recent controversy over the proposed course of Route 18 in New Brunswick is an example of an attempt at this type of strategy. Environmentalists had complained that, because of the noise and air pollution which would be generated by cars traveling on it, and because of the proximity of the proposed roadway to residential and dormitory areas, an alternative route be found. This type of problem is especially critical in New Jersey because of its high density of roads—the highest in the nation.

However, caution should be exercised before implicating noise sources as health hazards. A recent *Star-Ledger* article[20] indicated that noise produced by passing Erie-Lackawanna trains in Bloomfield was a health hazard. Although the sound levels measured were mod-

erately high, 90-92 decibels, only five trains passed the residence near which the sound levels were measured during an eleven and a half hour period. Assuming that each train took five minutes to pass the residence, this would be only 25 minutes of exposure, hardly enough, even at 90 decibels, to be considered a health hazard.

An increased physician awareness of the adverse health effects of noise would allow the New Jersey physician to provide the advice and guidance necessary to protect his patients from dangerous and excessive exposure to noise.

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If a trip is undertaken for other than business purposes, the travel fares and expenses are personal expenses, and the meals and lodging are living expenses, none of which are deductible. Only expenses at the destination which are properly allocable to the taxpayer's business are deductible.

—IRS Rev. Rul. 74-292, 26 CFR 1.162-2 (1974)

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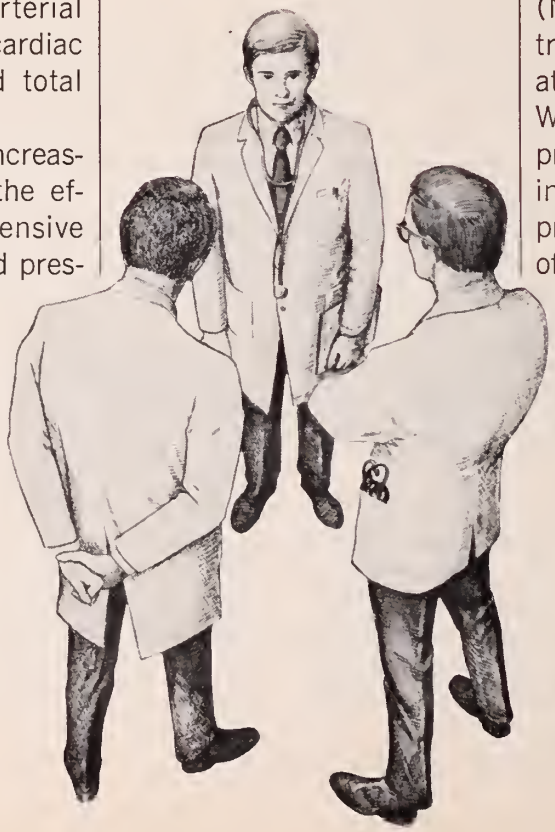

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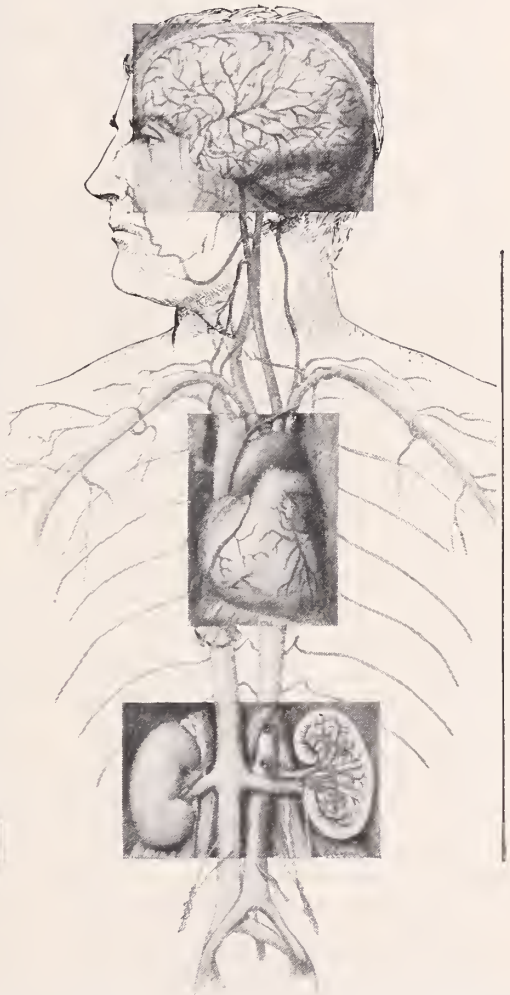

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It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

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Warnings: **It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.**

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

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Preliminary studies with acid enemas were carried out on a group of five patients who had clinical evidence of hepatic encephalopathy. Elevated blood ammonia is considered responsible for precipitating coma in chronic liver disease. Acidic Glucola® solutions as high colonic enemas were given, one hour daily for two to seven days. Glucola® was used as a trial substitute to lactulose, since it is harmless, cheaper, and equal in acidity. Arterial serum ammonia levels were measured before and after enemas were given. A decrease in serum ammonia levels ranged from 15 to 18 percent to 37 percent. Further studies on hepatic coma, utilizing acidic substances, varying treatment schedules, and a combination of other medications, are indicated.

Preliminary Studies with Acid Enemas and Their Effect on Hepatic Coma

H. Jackson, M.D., N. Riegel, M.D., S. Shastri, Ph.D., and E. Bongiovanni/Paramus*

Seventy-three percent of ammonia absorption from the human gut occurs in the colon, where it is split from protein and amino acids by urease-containing bacteria. Preventing absorption of these ammonia products should lower serum ammonia levels.

Neomycin has been used to suppress the bacterial flora of the intestinal tract, thus reducing ammonia production. Low protein diet and colonic bypass surgery have been utilized in an attempt to eliminate ammonia production from the gut.

Lactulose, a synthetic disaccharide is catabolized in the colon by lactobacilli into lactic, formic, and acetic acids.[17] Given orally, lactulose has been shown to ameliorate or prevent hepatic coma in patients with severe liver disease.[2] Lactulose has a pH of 3.8 in the colon after catabolism to organic acids, and may be effective because of its acidity. pH in the colon may shift the equation: $NH_3 + H^+ \leftrightharpoons NH_4$ to the right. The ammonia ion which is permeable to the colon membrane becomes impermeable after it is converted to the ammonium ion form. It is then removed from the colon in diarrhea material or enema content. Given orally, lactulose has been considered effective due to its laxative effect, its acidity, or to some other unknown mechanism. If the effect of lactulose were due to its acidity, the substitution of a harmless acid substance of an equivalent pH of 3.8 may lower serum ammonia levels equally well by reducing ammonia permeability and enhancing its excretion. Lactulose is not approved by the Food and Drug Administration in this country, therefore a cheaper, easily available, and effective substitute would be most desirable.

It was elected to begin with Glucola®† in our search for a suitable trial substitute for lactulose. Glucola® is a harmless substance, which is equal in acidity to lactulose (pH 3.8). If acidity is the major criterion by which ammonia is lowered in the serum, it was postulated that Glucola® should have an effect on serum ammonia levels equivalent to that of lactulose.

Method of Procedure

Five patients who had evidence of hepatic encephalopathy by accepted standards (disturbed consciousness and intellectual deterioration, associated hepatocellular disease, absence of other causes of mental obtundation),

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†A flavored, carbonated preparation of corn syrup which is commercially available in 7-ounce bottles, Ames Company, Elkhart, Indiana.

were studied.[11] All had abnormal liver function tests and four of the five had arterial hyperammonemia. Dehydration and hypokalemia were corrected before the study and other causes of mental obtundation were ruled out.

Each patient's level of consciousness was evaluated clinically according to the definitions of Plum and Poser.[1] A high colonic enema of neomycin was administered to one of the patients on one of the two days in which he was receiving Glucola® enemas. Four patients received neomycin orally until the day before the study, but this was discontinued when treatment with Glucola® enemas was started. Glucola® enemas were given once daily for from two to seven days. Arterial blood samples were drawn before and after completion of the Glucola® enema treatment.

NH_3 levels were measured by the method of Hutchinson and Labbey and were determined colorimetrically as ammonia nitrogen by the Hyland phenate-hypochlorite method.[15] Five hundred milliliters of Glucola® was diluted with water to a 1:20 solution and was given as a retention enema for one hour daily using a Bardex bulb.

Case Histories

Patient #1—A 61-year-old male chronic alcoholic, noted increasing jaundice and weakness for a year prior to admission. His condition gradually deteriorated over a six-day period of hospitalization. Glucola® enemas were administered for three days and during this period his arterial serum ammonia fell from 129 mcgm percent to 91 mcgm percent. There was no clinical response to the acid enemas, and the patient expired on the sixth day. Autopsy revealed advanced Laennec's cirrhosis and an abscessed prostate, which was probably responsible for septicemia.

Patient #2—A 47-year-old chronic alcoholic male, with documented Laennec's cirrhosis, was hospitalized because of increasing abdominal girth and jaundice. In the month prior to admission he had become lethargic and confused. The patient received Glucola® enemas daily for three days. The pre-enema arterial serum ammonia was 158 mcgm percent and the post-enema level was 133 mcgm percent. He was observed to become more responsive after receiving acid enemas. He then developed gram-negative sepsis and "hepato-renal syndrome" and expired.

Patient #3—A 22-year-old male heroin addict developed fulminant viral hepatitis with massive hepatic necrosis. Glucola® enemas were administered daily for two days, and the arterial ammonia level fell from 325 mcgm percent to 256 mcgm percent. This patient also received neomycin *via* high colonic enema on one day of the trial-study of Glucola®. He expired six days after admission, following a bout of hematemesis.

Patient #4—A 59-year-old male alcoholic was hospitalized because of jaundice and hallucinations for one week prior to admission. He had several previous admissions for ascites and ankle edema over a period of six years. Glucola® enemas were administered daily for one week, and clinical improvement was noted. During this period his serum NH_3 level fell from 223 mcgm percent to 202 mcgm percent to 127 mcgm percent. The patient expired suddenly, but permission for autopsy was refused.

Patient #5—A 47-year-old female was admitted in hepatic coma and treated with Glucola® enemas for several days. Serum ammonia levels were not obtained and the patient expired after ten days. There had been no clinical evidence of improvement throughout her course.

Discussion

Hepatic coma is a complex metabolic state which has been extensively studied but not yet entirely understood. It may result from failure of the liver to clear toxic substances or failure to contribute substances which the brain needs for metabolism. The most likely toxic substance not cleared by the failing liver is ammonia (NH_3). Methionine, enterogenous phenolic compounds, and short-chain fatty acids have also been suggested as possible cerebro-toxic substances,[7] but the majority of opinion favors elevated blood ammonia levels as responsible for precipitating coma in chronic liver disease.[9,10,5]

While four patients showed a decrease in arterial ammonia levels, the clinical results obtained with acid enemas were equivocal and not as dramatic as those obtained in a study using lactulose.[1]

Hepatic coma remains difficult to treat with a high mortality rate. The failure of acid enemas to improve the clinical status of these terminally ill patients who also had other problems, including sepsis and renal failure, does not exclude eventual benefit from the treatment. There was a decrease in post-treatment blood ammonia levels which ranged from 15.8 percent to 37 percent with an average of 26.1 percent (Table).

One patient received prolonged treatment with daily Glucola® enemas and showed a

Serum Arterial NH_3 Levels Before and After Treatment

Patient	Pre-Enema mcgm percent	Post-Enema mcgm percent	Percent Decrease
1	129	91	29.5
2	158	133	15.8
3	325	256	21.2
4	233	127	37.0

greater decrease in blood ammonia (37 percent) suggesting that the duration of the treatment may influence its effectiveness. There was no significant effect following the administration of neomycin on the first day of the trial in one patient.

Since an absorbable acidic substance, such as Glucola®, was able to reduce serum NH_3 levels, it is postulated that a totally non-absorbable acidic substance may prove even more effective, with more noticeable clinical benefit. Further studies on hepatic coma, utilizing a larger group of patients, varying the characteristics of the acid enema and the treatment schedule, and, perhaps, using them in combination with other medications, seem indicated.

Summary

A group of five patients in hepatic coma were given acidic Glucola® solutions as high colonic enemas, one hour daily for two to seven days. Serum ammonia levels were measured before and after the enemas in four of the five patients. It was shown in this small group of patients that the serum arterial ammonia level fell after the administration of the acid enemas. There was no consistent clinical improvement noted.

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Bergen Pines County Hospital

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*Bromberg W and Coyle E: Rape: A compulsion to destroy. *Medical Insight,* 6:21-25 April 1974

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CASE REPORT

A large echinococcus cyst of the liver in an Italian immigrant was successfully treated by a left hepatic lobectomy. Important diagnostic and therapeutic aspects of this disease are discussed. Advances in hepatic resection are described.

Echinococcus Cyst of the Liver in New Jersey: Treated by Left Hepatic Lobectomy

Nicholas J. Demos, M.D., et al.*
Jersey City

In spite of progress and improvement in health care around the world, echinococcosis remains a serious threat to life in endemic areas such as the eastern Mediterranean and South America. Treatment of an Italian immigrant with echinococcosis of the liver prompted this report.

Case Report: A 27-year-old emaciated Italian male was admitted to the Jersey City Medical Center on August 16, 1972, complaining of abdominal distress of two years' duration. His home was in the vicinity of Bari, Italy, when he emigrated to the United States 27 months before admission. Two years prior to admission he started having post prandial upper abdominal pain elicited by fatty meals and associated with epigastric fullness. In the recent months, the epigastric fullness was brought on by any meal and relieved by self-induced vomiting. He had had intermittent jaundice for the two-year period, but he denied blood transfusions or contact with jaundiced persons. He had not lived on a farm, nor had he contacted sheep.

On August 10, 1972, a liver needle biopsy at another hospital had showed bile canaliculi containing yellow material; liver cells contained bile pigment while the stroma was focally infiltrated with round cells. The diagnosis of bile stasis had been made. The color of his last stool 20 days previously was described as brown.

One brother had had cholecystectomy seven months previously, and another brother had testiculectomy for tuberculosis one year ago.

He denied alcohol consumption and had stopped smoking two months previously. Physical examination revealed an asthenic, emaciated male whose extreme weakness prevented him from turning in his bed unassisted from one side to the other. He was oriented and his skin color was yellowish. The liver was not palpable, but there was epigastric tenderness. Rectal examination revealed some hard, brown stool. Blood pressure was 120/70mm Hg., pulse was 72 per minute, his weight was 105 pounds.

Liver function tests were grossly abnormal with a high bilirubin, reversal of the albumin-globulin ratio, and high values for transaminase, alkaline phosphatase and cephalin flocculation. (See table).

Table

Liver Tests

Test	*Preoperative* August 1972	*Postoperative* October 16, 1972	June 9, 1973
SGOT	440	50	38
SGPT	400	64	25
Alk.-Phos'tase	up to 360	66	30
Alb/Glob.	2.3/4.4	3.1/4.3	4.6/2.4
Tot. Bilirubin	10.6	0.9	0.6
Direct Bilirubin	5.1	0.6	0.1
Ceph. floc.	+3		

A chest x-ray revealed old inflammatory disease in the right apex. Liver scan showed a large perfusion defect between the right and left lobes (Figure 1). Percutaneous cholangiogram was normal. Upper gastrointestinal series revealed an enlarged liver and normal esophagus, stomach, and duodenum.

Selective superior mesenteric arteriogram revealed the right hepatic artery to arise from the superior mesenteric artery. Celiac ateriogram showed the left hepatic artery arising from the celiac artery and displaced to the right by a mass in the left lobe of the liver (Figure 2). The venous phase of that angiogram revealed compression of the splenic vein (Figure 3), which explained the increased splenic uptake of the radioactive scan (Figure 1).

On September 8, 1972, through a bilateral subcostal incision, the left lobe of the liver was found to contain a thick walled cyst. The cyst measured 15 cm. in di-

*From the Department of Surgery, New Jersey Medical School, CMDNJ, Newark, where Dr. Demos is Clinical Associate Professor of Surgery, and the Departments of Surgery and Radiology of Jersey City Medical Center, Jersey City. Coauthors are Irving Singer, M.D., and Stephen Zinn, M.D., Clinical Associate Professors of Radiology; Maceo Howard, M.D., Clinical Associate Professor of Medicine, and V. Lim, M.D., Jersey City Medical Center.

ameter and subtotally replaced the liver parenchyma. After the left hepatic artery was doubly ligated, the ligamentous attachments of the left lobe were severed and the lobe was easily delivered into the wound. The medial attachment of the left lobe was partly fibrosed.

Figure 1—Liver scan showing near absence of the left lobe and increase in the splenic uptake.

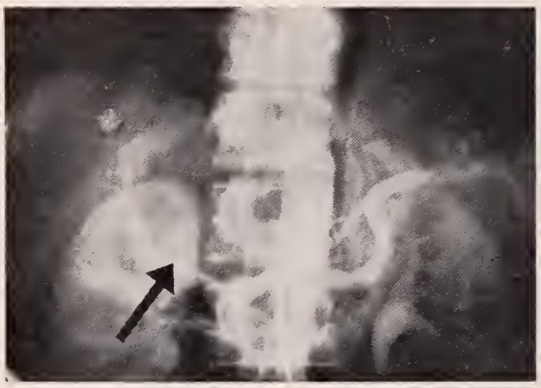

Figure 2—Celiac arteriogram shows pressure displacement (arrow) of the left hepatic artery.

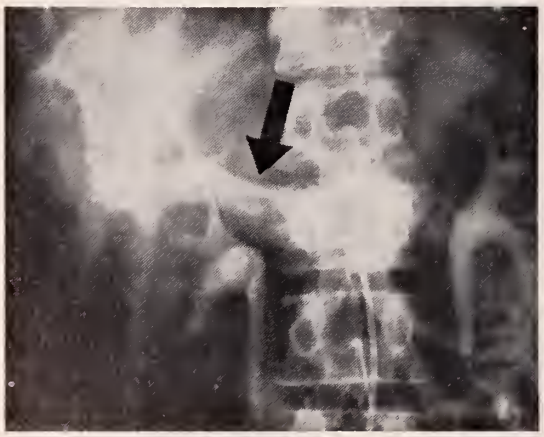

Figure 3—Pressure defect (arrow) of the splenic and portal veins on the venous phase of the celiac arteriogram.

Mattress sutures of heavy chromic catgut were inserted between the left lobe or the left lateral segment and the rest of the liver, and the cyst containing portion of the liver was resected by sharp dissection (Figure 4) and a cholecystostomy was performed with a Foley catheter.

Postoperatively, a large left subphrenic hematoma was evacuated. Recovery was slow with constant complaint of epigastric distress radiating posteriorly.

Cholangiograms through the cholecystostomy tube, one day after surgery, revealed suspicion of "sludge" in the left hepatic duct (Figure 5), but a repeat study a month later, showed a normal biliary tree with no dilations or obstructions (Figure 6). The cholecystostomy tube was removed, and he was discharged on October 24, 1972, with improved hepatic function tests

Figure 4—Half of the open specimen with daughter hydatid cysts inside and minimal remaining left hepatic lobe parenchyma outside the cyst.

Figure 5—Early postoperative cholangiogram through the cholecystostomy tube shows possible sludge in the common bile duct.

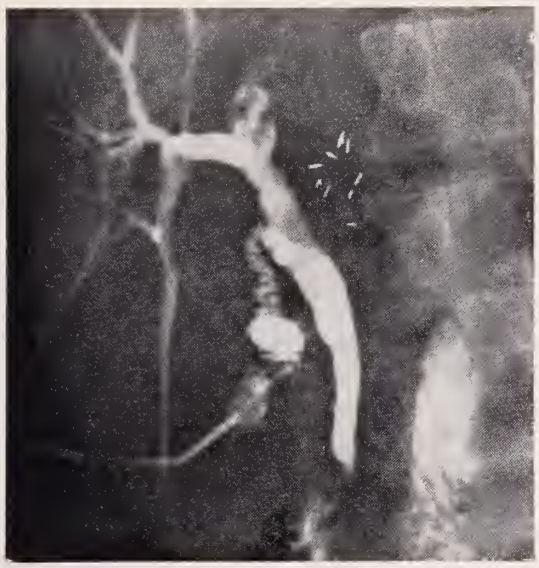

Figure 6—Late postoperative cholangiogram shows normal right lobe and common duct cholangiogram.

Figure 7—Postoperative liver scan shows possible slight left hepatic lobe regeneration and decrease in the splenic uptake.

(Table). The patient was hospitalized the following, month for a brief episode of pancreatitis associated with a serum amylase of 581 units.

Approximately five months after liver resection, scan revealed some liver regeneration in the left lobe (Figure 7), and nine months postoperatively, the albumen-globulin ratio had returned to normal (Table) and the patient had gained 19 pounds.

Diagnosis and Complications

Treatment of echinococcus cysts of the lung and heart has been rather standardized. Resection is the best form of therapy, but hepatic cyst poses serious diagnostic and therapeutic problems. Preoperative hepatic cholangiography, selective celiac and superior mesenteric arteriography, and liver scans are important diagnostic procedures.

Persons emigrating from Greece, Lebanon, and southern Italy, especially from the vicinity of Bari, are suspects for echinococcus disease which is endemic in those countries.

Of 2070 patients with echinococcus disease operated on at the Red Cross Hospital in Athens, liver cysts constituted 57.4 percent of the cases, lung cysts, 30.5 percent; cysts of the abdomen, spleen, kidney, and heart were found in decreasing frequency.[1,2,3] The complication rate accompanying hepatic echinococcus disease is quite high. Multiple cysts occur in 24 percent, coexisting gall stones in 15.5 percent, hepatitis in 10.5 percent, cirrhosis in 8.5 percent, secondary abdominal cysts in 6.5 percent, and rupture into the bile ducts, lung, pleura, and gastrointestinal tract in 8.5, 2.0, 0.8, and 0.3 percent respectively.

This high incidence of hepatitis and other abnormalities explains the derangement of hepatic function in our patient, as well as the occurrence of pancreatitis postoperatively. It also explains the protracted period of recovery.

The differential diagnosis lies between enlargement of the gallbladder, hydronephrosis, pancreatic cyst, and various forms of hepatomegaly.[5] Suppuration of the cyst must be distinguished from acute cholecystitis, cholangitis, and subphrenic abscess.[5]

Treatment and Results

The overall operative mortality in over 1200 cases, in the treatment of echinococcus disease of the liver was 8 to 12 percent according to Kourias.[1,2,3] Several procedures may be used according to the circumstances, but Kourias prefers total cystectomy in small or medium

size superficial or pedunculated cysts. These comprised 25 percent of his cases.

Hepatectomy, that is lobectomy or segmentectomy, may be performed in some cases. Right hepatic lobectomy carries a 10 to 14 percent mortality rate. The higher figure agrees with Mays' series of right lobectomies performed mainly for trauma[4]. Hilar ligation combined with finger fracture has the advantages of dry field, without the need of occlusion of the porta hepatis or the use of hypothermia. In our case, ligation of the left hepatic artery was performed prior to resection. Because the liver at the site of resection was cirrhotic, sharp dissection was essentially bloodless. Important technical features include maintenance of inferior caval flow, biliary drainage, and adequate external drainage. Postoperatively glucose and albumen infusions are mandatory. Partial regeneration of the excised parenchyma proceeds rapidly, but occurs to only a limited degree. (Figure 7) Mays reported significant enlargement of the portal vein supplying the regenerated mass of liver tissue after two years, but he noticed no new portal veins.[4]

Primary closure of the cavity was done in 30 percent of his cases. This method may be complicated by second infection, which may require drainage. Partial cystectomy, with external drainage for 2 to 3 weeks, is done in very ill patients. The evacuation of the cyst and filling of the cavity with omentum is rarely necessary. Kourias prefers marsupialization in older, very sick patients, however, this method may lead to biliary fistula, infection, cholangitis, hemorrhage, and electrolyte disturbances. In the majority of cases he used evacuation, partial cystectomy, and drainage by long drains.

Rupture into the chest cavity is treated by pulmonary resection and/or intercostal tube drainage in addition to the abdominal procedure. Rupture into the bile ducts is treated by choledochostomy and perhaps sphincterotomy.

Summary

A large echinococcus cyst of the liver in a 27-year-old Italian immigrant was successfully treated by a left hepatic lobectomy.

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INDICATIONS: All types of insomnia including elderly and chronically ill patients who have difficulty in falling asleep or frequent awakenings. Preoperatively and in the first stages of labor, it induces sleep without depressing respiration.

CONTRAINDICATION: Known hypersensitivity to glutethimide.

WARNINGS: Caution patients (1) about possible combined effects with alcohol and other CNS depressants; (2) operating machinery, driving motor vehicles or engaging in activities requiring complete alertness shortly after ingesting drug. Dosage of coumarin anticoagulants may require adjustments during and on cessation of glutethimide.
Physical and Psychological Dependence: Physical and psychological dependence have occurred. Prescribe cautiously for patients known to take excessive quantities of drugs. Limit repeated prescriptions without adequate medical supervision. Withdrawal symptoms include nausea, abdominal discomfort, tremors, convulsions, and delirium. Newborn infants of mothers dependent on glutethimide may also exhibit withdrawal symptoms. In the presence of dependence, dosage should be reduced gradually.
Pregnancy: Use of any drug in pregnancy or lactation requires weighing potential benefits against hazards.

PRECAUTIONS: Total daily dosage above 1 Gm. is not recommended for continued administration. In presence of pain, which may counteract the effect of glutethimide, an analgesic should also be prescribed.

ADVERSE REACTIONS: Withdraw glutethimide if a generalized skin rash occurs. Rash usually clears spontaneously within a few days after withdrawal. Occasionally, a purpuric or urticarial rash may occur; exfoliative dermatitis has been reported rarely. With recommended doses, there have been rare reports of nausea, hangover, paradoxical excitation, and blurring of vision. Rarely, acute hypersensitivity reactions, porphyria, and blood dyscrasias (thrombocytopenic purpura, aplastic anemia, leukopenia) have been reported.

DOSAGE: To avoid overdosage, individualize dosage. Not recommended for children under 12.
To induce sleep:
In insomnia: 0.25 to 0.5 Gm. at bedtime. Repeat dose if necessary, but not less than 4 hours before arising.
Preoperatively: 0.5 Gm. the night before surgery; 0.5 to 1 Gm. 1 hour before anesthesia.
First stage of labor: 0.5 Gm. at onset of labor. Repeat if necessary.

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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

September 15, 1974

A regular meeting of the Board of Trustees was held on September 15, 1974, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Blood Storage Revisions . . . Directed that request be made for clarification of Regulation 9.1, Physician's Supervision, in the proposed amendments to the State Sanitary Code relating to blood storage, collection, and processing, which states that when a physician is not present on the premises, the qualifications of phlebotomy supervisors and procedure standards shall be approved by the Department of Health.

. . . Directed further that if such clarification is acceptable, a written statement in favor of the regulation be transmitted to Dr. Martin Goldfield of the Department of Health as part of the record of the public hearing.

1975 Annual Meeting . . . Received as informative a notice from the Committee on Annual Meeting that the 1975 Annual Meeting will be held at the Garden State Convention Center, Cherry Hill, New Jersey from May 31 to June 3.

Hospital Survey Fees . . . Approved as amended the following recommendation from the Committee on Medical Education:

That a resurvey fee of $350 per hospital be established and implemented at the discretion of the Board of Trustees and the Chairman of the Committee on Medical Education.

. . . Directed that the Committee on Medical Education notify all hospitals that after January 1, 1975, the initial survey fee also will be $350.

Associate Editors . . . Approved the following recommendation from the Committee on Publication:

That William A. Dwyer, Jr., M.D. of Paterson; Bernard D. Pinck, M.D. of Passaic, and Richard H. Rapkin, M.D. of Newark be appointed Associate Editors of *The Journal*, MSNJ, without stipend, to carry out assignments as directed by the Editor.

Manuscript Review Board . . . Approved the following recommendation from the Committee on Publication:

That the selected candidates (see list on title page, this issue) be appointed members of the Manuscript Review Board, without stipend, and that the Editor, after consultation with the Chairman of the Committee on Publication, be authorized to make additional appointments as necessary.

Meetings with NJHA Executive Committee . . . Directed that the Executive Committee of the New Jersey Hospital Association be invited to meet with the Executive Committee of MSNJ on a monthly basis to discuss problems of mutual concern.

NJHA Board of Trustees' Meeting . . . Received a report from MSNJ liaison representative with the Hospital Association, Dr. John S. Madara, which included the following highlights:

(1) NJHA voted to work with MSNJ to seek a solution to the problem of unlicensed physicians.

(2) NJHA moved to support a survey of the midwifery course at CMDNJ.

(3) NJHA voted to ask the Council on Professional Practice to give consideration to the following: (a) trustees' responsibility in medical staff appointments and (b) pros and cons of open versus closed staff.

Note: A proposal to consider (b) (above) jointly with MSNJ was defeated.

(4) NJHA voted to urge MSNJ and the Governor to appoint a physician-member to the Health Care Administration Board.

Note: MSNJ had already submitted as candidates for the Health Care Administration Board the names of James George, M.D. and James S. Todd, M.D.

(5) NJHA moved to rescind its position statement on "free-standing ambulatory care facilities" for review and study.

(6) NJHA approved A-1332 which permits pharmacists to substitute generic name drugs for brand name drugs; reconsidered A-1257 which permits pharmacists to substitute brand name drugs with notification to the doctor if it reflects lower cost to consumer; and approved S-665 (Nursing Practice Act).

(7) NJHA voted to approve joint educational workshops on PSRO by NJHA and the New Jersey Foundation for Health Care Evaluation.

Channel 7 Telecast . . . Directed that a letter be sent to the Executive Producer of channel 7 and to Roger Sharp, the commentator of a program entitled "You're Okay, Hospitals Are Sick," commending them for the objectivity shown in the telecast and offering the Society's assistance in production of a similar program on physicians.

. . . Directed that a copy of this letter be sent to Channel 4.

Community Medical Center in Morristown . . . Directed that a request be made to Dr. Albert Abraham for additional information concerning the Community Medical Center in Morristown which is advertising a program of examinations by physicians in a situation whereby the hospital will profit from the center's services.

. . . Directed further that upon receipt of this information, the Executive Director respond to Dr. Abraham suggesting proper contacts and offering assistance in resolving the problem.

Resignation from Board of Trustees—Francis J. Benz, M.D. . . . Received notice that Francis J. Benz, M.D. had resigned as Secretary of the Board of Trustees and as Trustee representing the First Judicial District. (Dr. Edward Bourns was designated Secretary of the Board by unanimous ballot.)

. . . Directed that a letter be sent to Dr. Benz expressing commendation for past efforts as a member of the Board and conveying best wishes for future endeavors.

. . . Directed further that the component societies be requested to submit nominees for the vacancy in the First Judicial District for consideration by the Board in October.

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Communicable Disease Control Program of the New Jersey State Department of Health during September 1974:

	1974 September	1973 September
Aseptic meningitis	20	67
Primary encephalitis	5	7
Hepatitis: Total	214	185
Infectious	86	98
Serum	52	37
Unspecified	76	50
Malaria: Total	1	1
Military	0	1
Civilian	1	0
Meningococcal meningitis	2	3
Mumps	7	17
German measles	12	9
Measles	7	23
Salmonella	132	104
Shigella	48	75
Tuberculosis	81	
Syphilis: Total	74	
Primary	34	
Secondary	40	
Gonorrhea	1600	

Note: Gonorrhea, syphilis, and tuberculosis are figures for the previous month.

Change in School Tuberculin Testing Requirements

For the past several years the rules of the State Board of Education have required that children in grades 1, 5, 9, and 12 be tuberculin tested. State law also requires an annual examination of teachers, which in practice meant either a tuberculin test or a chest x-ray. Over half a million individuals have been subjected to these tests each year.

Among pupils, over 95 percent of those registered have been tested in the public schools. For example, in the school year 1972-73 reports to the State Department of Health show that 416,783 children were tuberculin tested (most with the tine test). This resulted in the discovery of 2,410 reactors, each of whom was required to have a chest x-ray. Of this number, only 387 had chemoprophylaxis with isoniazid (INH) recommended. It is not known how many children actually started to take INH or how many completed this preventive treatment.

There is no evidence that giving a larger dose (10 mg/kg) or providing INH for a period beyond one year results in any increase in benefit. Preventive value has been conclusively demonstrated and lasts for many years, if not for life.

On the recommendation of the State Department of Health, the State Board of Education, in 1974, made substantive changes in their rules since experience of several years showed that most grades had a reactor rate of less than 1 percent. The national criterion is that if the reactor rate is less than 1 percent, further testing is not indicated.

Tuberculin testing in the schools or any other general population group is not useful as a means of discovering tuberculosis. Experience of several years under the old regime demonstrated that almost no new cases of tuberculosis were discovered; those that did come to light were previously known. Current good practice indicates that one should start with the clinically ill patient who is diagnosed as having tuberculosis and then examine all of his or her close contacts. This is a much more effective disease control method than the old mass chest x-ray surveys, which are now in disrepute, or tuberculin surveys done without any special indication.

Other important changes in the rules relate to teachers and other employees. If a teacher had a negative tuberculin test in the previous school year, no further testing is necessary for three years. If the individual had a positive reaction from the Mantoux test (or if from a multiple puncture type tuberculin test, confirmed by the Mantoux test), that individual must have a chest x-ray. If the x-ray is negative, the individual is a candidate—just as reactor school children are—for one year of chemoprophylaxis with INH. However, INH is not without undesirable side effects. The incidence of hepatic dysfunction increases with age and the recently published national guidelines, which constitute a definitive statement on INH-associated hepatitis, indicate that INH should not be given prophylactically on a routine basis to individuals over the age of 35. Each case must be considered individually and a decision made as to the relative risk of hepatic dysfunction on one hand and the development of tuberculosis disease on the other. It is planned that the full detailed statement on this subject will be made available to physicians throughout New Jersey later this year, after it has been published in the American Review of Respiratory Disease.

Because of the possible side effects, INH should be dispensed so that the reactor will be seen by a physician or nurse monthly, and observed and questioned about signs and symptoms.

Therapeutic Drug Information Center

The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center of the New Jersey Regional Medical Program and the Brookdale Inter-regional Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, conjointly compile the information contained in this column each month. The New Jersey component is located at the Valley Hospital in Ridgewood. The Center serves as a source of intelligence on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions, and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor of Pharmacy and Director of Drug Information, Brooklyn College of Pharmacy, is Project Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College is pharmacologist consultant. The service is free, available Monday through Friday from 9 a.m. to

5 p.m.—telephone (201) 445-4900, extension 132. Following are questions and answers handled by the Center recently.

1. In the lay press there have been articles about dihydrogenated ergot alkaloids (DEA) for relieving symptoms of aging. Are these commercially available? Are they effective?

Dihydrogenated ergot alkaloids are commercially available as dihydrogenated alkaloids of ergotoxine (Hydergine®) containing equal parts of dihydroergocornine methanesulfonate, dihydroergocristine methanesulfonate, and dihydroergokryptive methanesulfonate. The dosage forms available are tablets for sublingual administration and a parenteral form. The labeling of Hydergine® now contains an indication for the treatment of selected symptoms in elderly patients, and states that short-term modest improvement has been demonstrated in such symptoms and levels of performance as mood-depression, confusion, self-care, unsociability, and dizziness.[1]

There have been numerous studies performed utilizing Hydergine® in geriatric patients to determine its value in relieving symptoms of cerebral insufficiency.

Rosen[2] conducted a study with 51 geriatric patients to evaluate the efficacy of Hydergine® in relieving the symptoms of chronic cerebrovascular insufficiency at a dosage of one milligram three times a day administered sublingually for twelve weeks. Eighty-two percent of the patients were described as "very much improved." The author suggested that the Hydergine® improves cerebral metabolism, which finally results in reduced vascular resistance and increased intracerebral blood flow.

Roubicek, *et al.*[3] conducted a series of psychological and psychopathological studies in 22 pairs of non-psychotic patients (average age 78.7 years) matched in sex, age, and previous occupation. The patients received by mouth 4.5 mg of Hydergine® or placebo daily for three months, according to a randomized schedule under double-blind conditions. Of 21 clinical and psychological variables, 13 showed a significant improvement with Hydergine®, and two with placebo. Statistically significant improvements with Hydergine® were noted for affectivity, psychomotor activity, and for global estimation of 18 items in a behavioral and psychological rating scale.

Jennings[4] treated 50 geriatric patients with symptoms of cerebrovascular insufficiency; 24 were treated with Hydergine® in a dosage of two 0.5 mg tablets three times daily for 12 weeks; and 26 were treated with placebo. Compared to the placebo group, the Hydergine® group improved significantly with respect to cognitive and intellectual capacity, attitude and mood, and physical complaints. Improvement was manifested particularly by relief of such symptoms as confusion, depression, uncooperativeness, fatigue, anorexia, and dizziness. The Hydergine® patients also became mentally more alert and had greater initiative.

Banen[5] treated 78 geriatric patients with symptoms and signs of cerebrovascular insufficiency with either Hydergine® or a placebo in a randomized, double-blind manner for 12 weeks. Changes in the patients' conditions were measured in three areas: attitude and behavior, cognitive and intellectual ability, and physical complaints. Analysis of the data revealed that Hydergine® most significantly improved items pertaining to the patients' attitude and behavior.

Bazo[6] carried out a trial in 66 geriatric patients with various complaints of the aged attributed to cerebral arteriosclerosis with cerebrovascular insufficiency. He stated that Hydergine® was significantly superior to papaverine in relieving impaired mental alertness, confusion, irritability, hostility, emotional lability, depressive mood, and lack of motivation in geriatric patients. The greatest benefits of Hydergine® therapy seemed to be in the areas of intellectual function or cognitive.

A case report appeared where treatment with Hydergine® resulted in dramatic improvement in a patient with confirmed presenile brain atrophy (Alzheimer's disease).[7] However, a recent *Medical Letter* review of Hydergine® concluded that there is no convincing evidence that Hydergine® has any value in treatment of cerebral arteriosclerosis or senile behavior.[8]

In conclusion, it appears that Hydergine® has shown some beneficial effects, at least on a short-term basis, in treating certain selected symptoms in elderly patients.

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[7]Burian E: An ergot alkaloid preparation (Hydergine®) in the treatment of presenile brain atrophy (Alzheimer's Disease): case report. *J Am Geriatr Soc* 22:126-128 (March) 1974

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2. Do you have any information concerning the use of propranolol in the treatment of migraine headache?

Propranolol (Inderal®) a drug currently indicated in the treatment of angina pectoris due to coronary atherosclerosis, cardiac arrhythmias, hypertrophic subaortic stenosis, and pheochromocytoma, has been observed in some patients to relieve coexisting migraine.

In a double-blind study testing 80 mg propranolol daily against a placebo for the prevention of migraine over 75 percent of the patients showed a good to excellent response.[1] Weber[2] reported that 79 percent of the patients taking propranolol obtained greater than 50 percent reduction in both frequency and severity of migraine regardless of age, sex, or migraine subtype.

Ludvigsson[3] studied 32 children between the ages of 7 and 16 who suffered from migraine. Of the 28 patients who completed the study, 20 were completely free from headache while on propranolol, 3 showed good improvement, and 3 showed modest improvement. This author stated that propranolol caused no serious side effects if patients with heart decompensation, asthma, or atrioventricular block were excluded from the treatment.

However, Blank and Rieder[4] suggested caution in the non-discriminative use of propranolol in patients with migraine. They reported the case of a 40 year old patient who received 60 mg propranolol daily for cardiac symtoms and developed severe exacerbation of migraine attacks which were refractory to ergot preparations.

The precise rationale for propranolol's use in migraine hasn't been fully developed. Propranolol does block vasodilator receptors in adrenergically innervated vessels.[2,3] It also inhibits glycogenolysis and glycolysis. A result of this latter effect would be the removal of a metabolic vasodilator influence on cerebral vessels at the tissue level.[3]

In conclusion, our search indicated that propranolol may be an effective adjunct in the treatment of migraine, but additional well-controlled studies are needed to corrohorate this fact.

References

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[2]Weber R: Rational treatment of migraine. *South Med J* 65:737-740 (June) 1972

[3]Ludvigsson J: Propranolol in the treatment of migraine in children. *Lancet* II:799 (Oct 6) 1973

[4]Blank N and Rieder M: Letter to Editor. Paradoxical response to propranolol in migraine. *Lancet* II:1336 (Dec 8) 1973

3. What is the recommended influenza vaccine for the 1974-1975 season? Is it different from that available last year? What is the recommended schedule for vaccination?

Influenza virus vaccine, bivalent, for 1973-1974 contained not less than 1000 chick cell agglutinating units (CCA) of antigen in the following proportions: 700 CCA units of type A strain comparable to the prototype, A England /42/72 (H3N2) and 300 CCA units of type B strain, B/Massachusetts /1/71.[1] In order to achieve optimal protection, a monovalent influenza vaccine type B was recommended as a supplemental vaccine for those who were to receive bivalent vaccine. The administration of the two vaccines was recommended to be two weeks or more apart to enhance an overall type B antibody response.

The Bureau of Biologics, Food and Drug Administration, reviews influenza vaccine formulation regularly and recommends reformulation with contemporary antigens when indicated. Influenza virus vaccine, bivalent, for 1974-1975 contains a new type A influenza virus representative of currently prevalent "England" strains. Each adult dose (0.5 ml) of the 1974-1975 vaccine contains not less than 1200 chick cell agglutinating (CCA) units of antigen in the following proportion: 700 CCA units of a type A strain comparable to the prototype, A/Port/Chalmers/1/73 (H3N2) and 500 units of a type B strain, B/Hong Kong/5/72.[2]

Influenza control through widespread vaccination is not currently a public health objective, but annual vaccination is recommended for the older age group and for persons of all ages who have such chronic conditions as (1) heart disease of any etiology, particularly with mitral stenosis or cardiac insufficiency; (2) chronic bronchopulmonary diseases, such as asthma, chronic bronchitis, bronchiectasis, and emphysema; (3) chronic renal disease; and (4) diabetes mellitus and other chronic metabolic disorders.

The primary series of influenza virus vaccine, bivalent, has traditionally heen two doses given at an interval of approximately two months. Data indicates that with the more potent influenza vaccines available in recent years, the second dose provides little additional benefits. It is now considered reasonable, therefore, to give only one injection, preferably by the intramuscular route, of bivalent vaccine for either primary or annual booster use. Monovalent type B is not recommended this year. Influenza vaccination should be scheduled for completion by mid-November. Adults and children 10 years of age and older should receive 0.5 ml of vaccine. Children 6 to 10 years of age should receive 0.25 ml. Vaccine should not be administered to persons hypersensitive to egg protein.[3]

References

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[2]Anon: Recommendation of the Public Health Service advisory committee on immunization practices. *Morbidity and Mortality Weekly Report* 23:215 (June 15) 1974

[3]Anon: New formulation. *PharmIndex* 16:11 (Aug) 1974

4. Do you have any information concerning the use of aspirin in preventing myocardial infarction or reducing its mortality rate?

The ingestion of aspirin has been shown to alter coagulation mechanisms, the most important of which may be platelet aggregation. Therefore, it has been suggested that aspirin may he useful if used prophylactically in thromboembolic conditions such as coronary artery thromhosis.

The Boston Collaborative Drug Surveillance Group[1] conducted two studies which suggested that aspirin may reduce the incidence of myocardial infarction (MI). In the first, among 325 patients with acute MI, 3 (0.9%) gave a history of regular aspirin use before admission, whereas among 3,807 controls, 188 (4.9%) gave such a history. In the second, among 451 patients with acute MI, 16 (3.5%) have a history of regular aspirin use before admission, whereas among 10,091 controls 702 (7.0%) gave such a history. Both studies, therefore, showed a negative association between regular aspirin ingestion and non-fatal MI. Unfortunately, although factors such as age and sex were eliminated from the trials, factors such as diet, personality, and exercise were not.

Elmwood, *et al.*[2] studied 1,239 men who had had a recent MI, and although statistically inconclusive, in those patients receiving aspirin there was a reduction in total mortality at six months and at 12 months after admission to the trial compared to a placeho group.

Isomaki[3] studied 1,000 rheumatic patients who were receiving aspirin and stated that patients taking 26-500 grams of aspirin yearly had as many MIs as patients taking aspirin only occasionally or not at all. However, Wood[4] re-evaluated Isomaki's statistics and stated that the initial conclusion may have been incorrect, and in fact aspirin may have reduced the incidence of mortality.

In conclusion, some evidence is accumulating that regular aspirin ingestion reduces the possibility of MI. However, before aspirin can be recommended as a safe and effective agent for preventing or reducing its mortality rate, trials are required to establish whether this effect is real.

References

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[4]Wood L: Letter to Editor. Aspirin and myocardial infarction. *Lancet* 2:1021:1022 (Nov 11) 1972

5. Can drugs used for oral cholecystography cause acute renal failure?

The use of both iopanoic acid (Telepaque) and ipodate calcium (Oragrafin), the two most popular agents used for oral cholecystography, have been associated with a low incidence of serious renal effects including acute renal failure.[1,2,3] The clinical course of acute renal failure is manifested by oliguria or anuria and an elevated BUN beginning a few hours after cholecystography. Most patients have recovered without sequelae in a few days. A review of cases attributed to oral cholecystographic agents shows that most, if not all, cases occurred in patients with severe hepatic dysfunction or extrahepatic biliary obstruction. Most also followed the use of excessively high doses of oral cholecystographic agents, many of which were repeat tests because of failure of visualization after an initial dose.

Sanen and co-workers[1] reviewed the reported cases of acute renal failure associated with oral cholecystography, and conducted a study in which oral cholecystographic agents were used in normal individuals and in patients with either advanced renal or hepatic disorders. They concluded that clinical and pathological evidence suggested that acute renal failure was caused by an ischemic circulatory factor, particularly in the presence of severe hepatic derangement or extra hepatic biliary obstruction. Further, pre-existing renal disease did not seem to be a contributory etiologic factor.

In conclusion, the utilization of oral cholecystographic agents in large or repeated doses in the presence of marked hepatic insufficiency or biliary tract disease are the factors which tend to increase the risk of serious renal side effects in patients who undergo oral cholecystography.

References

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[3]Canales C *et al.:* Acute renal failure after the administration of iopanoic acid as a cholecystographic agent. *N Engl J Med* 281:89-91, 1969

[4]Sanen F, Myerson R, and Teplick J: Etiology of serious reactions to oral cholecystography. *Arch Intern Med* 113: 241-247, 1964

6. Is the Kveim test available?

The Kveim test, first described in 1935, is an intradermal skin test used in the diagnosis of sarcoidosis. The test utilizes a serum suspension of human sarcoid tissue that has been carefully standardized[1]. It is well established that some components of this suspension provoke, when injected intradermally in a patient with active sarcoidosis, the slow development of an epitheloid granuloma of a sarcoid type. A dose of 0.1 to 0.2 mls of crude Kveim antigen is injected into the flexor surface of the forearm and the innoculation site is observed for the development of a visible and palpable nodule during the ensuing six weeks.[2] The nature of this Kviem reaction is unknown though it may be a manisfestation of hypersensitivity.

There is no commercial source of this antigen: therefore, the physician employing this test must find a medical center with some standardized antigen and a clinician who is familiar with the performance of this test.[3] (There is a great deal of variation from laboratory to laboratory in preparing this antigen suspension.)

The specificity of the test has been questioned. False negative results may amount to 30-40 per cent, the percentage increases with duration of disease. False positive results may occur in Crohn's disease and in apparently healthy subjects who fail to undergo tuberculin conversion after 2 BCG vaccinations. There are also errors in technique both in performing the test and in reading it which can influence the results.[2]

In conclusion, the Kveim test may be useful to confirm the clinical diagnosis of sarcoidosis. The physician desiring to utilize this diagnostic procedure must locate a source of the antigen since it is not commercially available.

References

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[2]Douglas A: The Kveim Test and its practical significance. *Scand J Resp Dis Suppl* 80:61-70 1972

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Meet Our Associate Editors

William A. Dwyer, Jr. Bill Dwyer is a surgeon with special interest in trauma and emergency medical services, as well as writing. In addition to a number of scientific articles, Dr. Dwyer has authored numerous papers on socio-economic subjects in *Medical Economics, Hospital Physician,* and other journals. A member of the American Medical Writer's Association, he also serves as editorial consultant for *Surgical Team* magazine.

A lifelong resident of New Jersey, he was educated in public and parochial schools in Paterson, the Newark Academy, Princeton University, and New York University School of Medicine. Surgical residency training at Bellevue Medical Center, followed by a stint as instructor in surgery at the University of Missouri, ultimately led to a private practice at St. Joseph's Hospital, where Dr. Dwyer is a senior attending surgeon. His accomplishments include certification by the American Board of Surgery and Fellowship in the American College of Surgeons.

Dr. Dwyer is an active member of the Passaic County Medical Society and served that component as its president and as a delegate to the Annual Meeting. He is also a member of the National Academy of Sciences Sub-committee on Emergency Medical Services, the A.C.S. Committee on Trauma, and is an advisor to the New Jersey Interagency Council on Emergency Medical Services.

Bill and his wife, the former Janet Roberts, reside in Wayne, New Jersey, with their son and two daughters.

Bernard D. Pinck, M.D. The author or co-author of 34 scientific articles, which have appeared in major national scientific journals and publications, as well as the *JMSNJ,* Bernard D. Pinck will bring his talents and his experience as a surgical sub-specialist to the service of our *Journal.* A urologist, he was graduated from Johns Hopkins University where he received both an A.B. and M.D. degree. After a surgical internship and initial residency at the Johns Hopkins Hospital, he completed his urological training at the New York Post-graduate Hospital.

Dr. Pinck served in the Army in the Second World War and subsequently entered the private practice of urology in Passaic, New Jersey. He serves as director of urology at Passaic General Hospital and Beth Israel Hospital and as attending urologist at University Hospital and Bellevue Hospital (New York). He holds the academic title of Associate Professor of Urology, New York University School of Medicine, and is consultant urologist to the Chilton Memorial Hospital and the South Bergen Hospital. He is certified by the American Board of Urology, a Fellow of the American College of Surgeons, and a member of the American Urological Association and of the Academy of Medicine of New Jersey.

Doctor Pinck is married to the former Gladys Pasternack and they are the parents of three children.

Richard H. Rapkin, M.D. Richard Rapkin is an enthusiastic academically-oriented pediatrician, who has published more than 20 scientific papers in his field, while accumulating both clinical practice experience and teaching know-how. His special interest has been diagnosis and treatment of infections in clinical pediatrics.

Dr. Rapkin was educated at Drew University and Albert Einstein College of Medicine, following which he had both pediatric internship and residency training at Yale-New Haven Medical Center. As a Captain in the Medical Corps, he served as Chief of Pediatrics at the U.S. Army Hospital, Fort Leonard Wood, Maryland, and then entered private pediatric practice in Somerville, New Jersey.

Richard is a diplomate of the American Board of Pediatrics, a Fellow of the American Academy of Pediatrics, and a member of the AOA Honor Medical Society, the Academy of Medicine of New Jersey, the Ambulatory Pediatric Association, and the New Jersey Thoracic Society.

Presently, Dr. Rapkin is Associate Professor of Pediatrics, CMDNJ—Rutgers Medical School, and is Director of Pediatric Services at the Raritan Valley Hospital. He is married to the former Louise Lerner and they have four children ranging in age from 5 to 14 years.

The Problem Oriented Medical Record in the Doctor's Office

The following presentation was given by Donald F. Kent, M.D. of Summit, before the Section on Family Practice at the 208th Annual Meeting, MSNJ, May 13, 1974, Atlantic City.

The Problem Oriented Medical Record System is a means of chart organization so that a patient's problems are prominently displayed and can be referred to in providing continuing care.

The System, designed by Doctor Lawrence Weed, is simple. There are many ramifications and added features which the practicing physician may or may not wish to adopt for his own use. There are four basic steps. These include (1) the acquisition of the data base, (2) the formulation of the problem list, (3) the writing of an initial plan, and (4) the progress notes and the discharge summary.

(1) The data base is merely the history, physical examination, and laboratory data necessary for a basic work-up on that particular patient in that location at that time. Thus the data base of a twelve-year-old girl differs from that of a seventy-year-old man. The point must be emphasized that the data base is predetermined by the physician and is always adhered to. It is worth pointing out that we are not talking about minor illnesses or episodic care. We are talking about patients who are being seen on a continuing basis.

(2) After the data base has been accumulated we can formulate the problem list. What is a problem? Basically, anything that requires a plan can be regarded as a problem. We customarily think of (1) well-defined diagnoses or syndromes, e.g. diabetes mellitus, (2) symptoms, e.g. chest pain, (3) abnormal physical findings, e.g. hepatomegaly, (4) psychosocial problems, e.g. alcoholism in spouse. These are listed as either active or on-going problems or as inactive or resolved problems. Note that we do not list temporary or minor problems for which a prompt resolution is expected, e.g. fractured arm, laceration, URI, gastroenteritis. If any of these temporary problems persist for more than three or four visits, they should be then listed on the regular problem list as an unresolved problem. The problems are numbered and are written in a prominent place on the chart, such as the inside of the front cover or in some other location commanding initial attention when the chart is opened.

(3) Having formulated a problem list, we can now write an initial plan to deal with each problem. Each problem is now listed and numbered and for it we consider three items:

(a) diagnostic procedures for "rule-outs," e.g. "EKG to rule out infarction," "chest x-ray to rule out pneumonia," and so on;

(b) therapeutic maneuvers, e.g. "Digoxin to control ventricular rate, penicillin for the infection," and

(c) patient education—what did you tell the patient and his family about his illness, its treatment and his prognosis?

It is obvious that the initial plan is written only once and that is after the accumulation of the data base.

(4) Finally, we write our progress notes using the same format. Each entry is titled and numbered to correspond to the problem list. The progress note is made in four categories. "S" for subjective—what did the patient say? "O" for objective—what did you observe, what are the physical findings, what are the laboratory findings? "A" for assessment—what do you think about this problem? "P" for the plan—what will you do?

Here again we use the same format as under the initial plan with a note about (1) diagnostic maneuvers, (2) therapeutic plans and, (3) a statement about patient education.

Flow sheets are a valuable adjunct. We can list those parameters we want to watch, e.g., weight, blood pressure, blood sugar, serum potassium, and so on, and simply fill in the numbers at each visit, thus giving the reader a rapid view of the patient's progress. Medications can be listed on the same sheet or a separate medical list can be used.

Practical Considerations: Inasmuch as changing over to POMR seems a very formidable task, the following points may help ease the way:

(1) If at all possible, go to letter-sized folders in open stack files. You save enormous amounts of space by doing this. One wall of open stack filing will hold more charts than drawer after drawer of closed files—and they are easier to get at. Winnow your files, retaining only those seen in the past two years—putting all other in an inactive category.

(2) If you simply cannot get away from your 5x8 folders, I suggest you have printed a problem list card, on slightly heavier stock of a different color from your chart. This can then be inserted into your 5x8 folder and you have your problem list readily available each time you open the chart.

(3) Don't try to convert to POMR all at once. Do each chart as you see the patient. You can actually do it while you are talking to the patient. Have on hand your new folder with a blank problem list printed on it and fill in the problems as you find them in the old record. It might take you as much as a minute or two, at the most, to make your problem list for the most complicated record.

(4) In writing your progress notes on a patient with more than one problem on return visits, you don't necessarily have to stretch out a "SOAP" on each problem. You can write an "S" on *all* the patient's remarks or statements made during that visit and on *all* the findings or you can simply write "Refer To Flow Sheet." Then under "A" you can write, for example, Problem #1: "Diabetes—under good control," Problem #2: "Hypertension—will need additional therapy," and so on. Finally under "Plan" you can write #2 Hypertension—"add Thiazide 25 mg. BID." The system is flexible and there is no need to write compulsively in each category each and every time the patient is seen.

(5) An additional helpful spin-off in the use of the POMR is the ease with which you can now code your diagnoses. By using standardized diagnostic terms, such as provided by the list of the Royal College of General Practitioners of Great Britain, you are in a position to have each diagnosis coded. This work can be done by any reasonably intelligent office assistant or by extra help hired for this purpose. By coding your diagnoses, you can set up a Disease Cross Index File.*

(6) Many physicians, long in practice, recognize the value of the POMR, but reason that their own records are unsuitable for conversion or that the task is simply too great. Speaking as one who made the shift after some twenty-five years of practice, I can say that the job was not that difficult and that the results were an obviously improved system, increased pleasure in my daily work, and enhanced patient care.

Nearby HEW Regional Offices

Region II New York
New Jersey
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and Virgin Islands
Federal Building
26 Federal Plaza
New York, New York 10007
(212) 264-2500

Region III Pennsylvania
Maryland
Delaware
Virginia
West Virginia
District of Columbia
Post Office Box 13716
Philadelphia, Penn. 19101
(215) 597-6674

*Warburton S W: "E" book and its implications for family practice. *JMSNJ* 71:553-557, 1974.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

CARDIOLOGY—George E. Berk, M.D., Ridder Apts. 4-5, Apt. 3-D, Valley Road, Manhasset, N.Y. 11030. Cornell 1968. Board eligible. Group, institution, cardiac catheterization opportunity. Available July 1975.

GENERAL PRACTICE—Young S. Kim, M.D., 420 Stockholm Street, Apt. B-10, Brooklyn, New York 11237. Yonsei (Korea) 1964. Board eligible in internal medicine. Solo partnership, or group. Available January 1975.

INTERNAL MEDICINE—Yen-Jen Fuh, M.D., University Hospital, University of Kentucky, Lexington, Kentucky 40506. National Taiwan University 1963. Board certified. Group or partnership. Available.

John V. Mendola, M.D., 289 Kerrigan Boulevard, Newark 07106. Hahnemann 1972. Board eligible. Small group, partnership, or solo. Available June 1975.

P. Govindarajan, M.D., 12000 Fairhill Road, Apt. 502, Cleveland, Ohio 44120. Madras University (India) 1966. Board certified. Subspecialty, gastroenterology. Group partnership, hospital, or solo. Available July 1975.

Joonhi Choi, M.D., 636 Brooklyn Ave., Apt. 8-11, Brooklyn, New York 11203. Seoul National University (Korea) 1964. Board certified. Subspecialty, hematology. Solo, group, or association. Available.

Stanley F. Bernstein, M.D., 406 Hillside Ave., Boonton, N.J. 07005. CMDNJ 1972. Board eligible. Group or partnership. Available July 1975.

Augustin J. Schwartz, III, M.D., 14163 Castle Blvd., Apt. 403, Silver Spring, Md. 20904. Jefferson 1971. Board certified. Subspecialty, oncology. Group or partnership. Available July 1975.

Hui-Yen Chang, M.D., Dept. of Dev. Therapeutics, Anderson Hospital, Houston, Texas 77025. Taipei (Taiwan) 1966. Board eligible. Subspecialty, oncology. Group, partnership, or hospital. Available July 1975.

NEUROLOGY—Sang Jin Yoo, M.D., 4470 Granada Boulevard, Apt. 7, Warrensville Heights, Ohio 44128. Yonsei (Korea) 1969. Group or solo. Available January 1975.

OBSTETRICS AND GYNECOLOGY—Anant R. Bhati, M.D., 506 Dixmyth Avenue, Cincinnati, Ohio 45220. S.M.S. Medical College, Jaipur (India) 1964. Board eligible. Group, partnership, or solo. Available August 1974.

Iqbal Karim, M.D., 509 Lafayette Ave., Apt. 6, Buffalo, N.Y. 14222. Dow (Pakistan) 1970. Solo, partnership, or group. Available July 1975.

ORTHOPEDIC SURGERY—Muhammad Umar, M.D., 1945-25G Eastchester Rd., Bronx, N.Y. 10461. King Edward (Pakistan) 1969. Board eligible. Group, partnership, or solo. Available July 1975.

OTOLARYNGOLOGY—Nae H. Park, M.D., 515 West 59th Street, Apt. 5-N, New York 10019. Kyung Pook (Korea) 1966. Board eligible. Solo, partnership, group. Available July 1, 1975.

Nabeel M. El Romman, M.D., 921 St. Ann Place, Richmond, Virginia 23225. Cairo University 1968. Partnership or solo. Available July 1975.

PEDIATRICS—Joseph A. Hesch, M.D., Box 62, Avalon, New Jersey 08202. Jefferson 1934. Board certified. Part or fulltime, salaried, clinical or executive. Available March 1975.

Arnold Kramer, M.D., 445 Edgemont Avenue, Palmerton, Pa. 18071. Duke 1962. Board certified. Association. Available.

Isaac G. Doron, M.D. Stevens Clinic Hospital Apts., Welch, West Virginia 24801. Cairo University (Egypt) 1953. Board eligible. Group or partnership. Available.

Daniel J. Rowe, M.D., 27212 Calaroga Ave., Hayward, Calif. 94545. New Jersey School of Medicine, CMDNJ, 1965. Board certified. Group. June 1975.

SURGERY—Peter Salzer, M.D., 200 Carman Avenue, Apt. 13-A, East Meadow, New York 11554. Tufts 1970. Group. Available July 1, 1975.

Emil Von Arx, M.D., 55 Culberson Road, Basking Ridge 07920. Boston University 1967. Board eligible. Group or partnership. Available.

Stephen Green, M.D., 6938 Post Street, Edwards AFB, California 93523. NYU 1966. Board certified. Solo or partnership, northeastern part of State. Available July 1975.

Steven A. Dressner, M.D., 435 E. 70th St., Apt. 9-K, N. Y. 10021. Cornell 1968. Board eligible. Subspecialty vascular surgery. Solo, group, partnership, hospital. Available May 1975.

Arieh Kaynan, M.D., 1249 Park Ave., Apt. 2-B, New York 10029. Hadassah (Israel) 1965. Board eligible. Subspecialty, vascular surgery. Group or institution. Available July 1975.

UROLOGY—J. M. DeCento, M.D., Woodbine Road, Shelburne, Vermont 05482. Vermont 1973. Association, Available July 1975.

Joel W. Goldsmith, M.D., 5700 Arlington Ave., Bronx, N.Y. 10471. SUNY Downstate 1971. Board eligible. Solo or partnership. Available July 1975.

Stefan Loening, M.D., 9500 Euclid Ave., Cleveland, Ohio 44106. Freiburg (Germany) 1965. Board eligible. Group, partnership, or solo. Available October 1975.

Aurelio Benavides, M.D., 733 Marshall Dr., Erie, Pa. 16505. Javeriana (Bogota, Colombia) 1970. Board eligible. Group or partnership. Available July 1975.

OWNERSHIP STATEMENT

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of August 12, 1970: Section 3685, Title 39, United States Code)

1. Title of Publication: THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY.

2. Date of Filing September 23, 1974.

3. Frequency of Issue: Monthly.

4. Location of Known Office of Publication: 315 West State Street, Trenton, New Jersey 08618.

5. Location of the Headquarters or General Business Offices of the Publishers (Not Printers): 315 West State Street, Trenton, New Jersey 08618.

6. Names and addresses of publisher, editor and managing editor: Publisher, The Medical Society of New Jersey, 315 West State St., Trenton, New Jersey 08618. Editor, Arthur Krosnick, M.D., 315 West State St., Trenton, New Jersey 08618. Asst. Editor, Mrs. Marjorie Treptow, 315 West State St., Trenton, New Jersey 08618.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given).: The Medical Society of New Jersey, 315 West State St., Trenton, New Jersey 08618 (a non-profit corporation of New Jersey).

8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities: None (a non-profit corporation of New Jersey).

9. For optional completion by publishers mailing at the regular rates (Section 132, 121, Postal Service Manual). 39 U. S. C. 3626 provide in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates." In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the reduced postage rates authorized by 39 U. S. C. 3626. (Signed)
R. H. Lambert, Business and Financial Manager
The Medical Society of New Jersey

10. For completion by non-profit organization authorized to mail at special rates (Section 132,122, Postal Manual). The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes have not changed during preceding 12 months.

11. Extent and nature of circulation:

	Average No. copies each issue during preceding 12 months	Actual number of copies of single issue published nearest to filing date
A. Total No. copies printed (Net Press Run)	9,266	9,400
B. Paid Circulation		
1. Sales through dealers and carriers, street vendors and counter sales	—	—
2. Mail Subscriptions	8,501	8,694
C. Total Paid Circulation	8,501	8,694
D. Free Distribution by mail carrier or other means		
1. Samples, complimentary, and other free copies	331	331
2. Copies distributed to news agents, but not sold	—	—
E. Total Distribution (Sum of C. and D)	8,832	9,025
F. Office use, left-over, unaccounted, spoiled after printing	434	375
G. Total (sum of E & F—should equal net press run shown in A)	9,266	9,400

R. H. Lambert, Business and Financial Manager
The Medical Society of New Jersey

The Scientific Exhibits — — 209th Annual Meeting

The following information is pertinent to the scientific exhibit display at the 209th Annual Meeting of this Society, May 31-June 3, 1975. Those interested in participating may use the application form on page 877. (Please complete both sides.) Remove the page from *The Journal* and mail directly to Francis X. Keeley, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Policy—It is the policy of the Committee on Scientific Exhibits of The Medical Society of New Jersey, in instances where a pharmaceutical company has aided in the production of an exhibit—either through financing or supplying products—that the name of the product or company is not to appear on any placards pertaining to the exhibit or on booth signs shown within the area of the exhibit, nor is it to appear in the description of the exhibit published in the program. However, the committee does not object to reprints of articles pertaining to the exhibit being distributed from the scientific exhibit booth. Scientific exhibitors are free to discuss with visitors to their booths products used in their presentations.

Space assigned will be an 8-foot deep booth (backwall and two sidewalls) of composition board covered with burlap. The backwall will vary according to the requirements of the exhibitor, and the measurement must be noted on the application. A shelf one foot wide is provided with each booth. The height of the wall above the shelf is 5 feet, 6 inches. However, the shelf will be removed if advance request is made. By eliminating the shelf, the booth will measure 8 feet in height.

Please indicate on the application if the exhibit is free-standing. Such an exhibit will not require a constructed booth.

Please indicate on the application if a sign is incorporated with your exhibit. If so, one will *not* be ordered.

If at all possible, a photograph of the exhibit should accompany the application. If a photograph is not available, a drawing will suffice.

Application for space in the Scientific Exhibit must be submitted no later than January 15, 1975, for consideration by the committee. Applications will be acted upon by the committee as soon after that date as possible and notification sent to all exhibitors. Send *completed* application, together with photograph or drawing of exhibit, to Francis X. Keeley, M.D., Chairman, Committee on Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton 08605.

1. *Time:* The exhibits will open officially at 12 noon, Saturday, May 31, and close at 5 p.m., Monday, June 2. On the intervening day the hours are 9 a.m. to 5 p.m.

2. *Installation and Dismantling:* Installation of exhibits may begin at 3 p.m., Friday, May 30, and all exhibits must be in place by 11 a.m., Saturday, May 31. Exhibits must remain intact until 5 p.m., Monday, June 2, and should be removed from the exhibit hall not later than 12 noon, Tuesday, June 3.

3. *Cost:* The Society provides free of charge such space exhibitor may require including booth with shelf printed sign (*if requested*), and lights for illumination. The exhibitor must pay the cost of installing the exhibit, of renting tables and chairs, and the alterations and special construction, *including electrical connections.*

4. *Sponsorship:* All exhibits must be shown in the name of individual persons. The name of the institution may appear as part of the address. Medical schools, hospitals, clinics, and other institutions and organizations should not present exhibits in their own names, but rather in the names of the individuals who worked up the exhibit.

5. *Use of Space:* No exhibit shall interfere with another exhibit. No part of the exhibit will be allowed to extend above the top of the booth.

6. *Aisles:* Aisles must be kept clear; to this end exhibits must be so arranged that they will be inside the booth space.

7. *Advertising:* No advertising matter of any description may be distributed, nor any material shown which in any way serves for commercial propaganda.

8. *Demonstrations:* All exhibits must be in charge of competent, well-informed demonstrators. The workers who did the actual work shown, or someone who is familiar with all details, **must be present at all times during exhibit hours.**

9. *Motion Pictures:* Motion pictures may be shown in booths. Films are subject to preview at the discretion of the committee. They shall be non-inflammable, and *silent.* The exhibitor must supply his own screen, projector, and operator.

10. *Liability:* It is agreed that exhibitors shall indemnify and hold blameless The Medical Society of New Jersey and Garden State Park Convention Center from all liability which may ensue from any cause whatsoever relating to the use of a booth by an exhibitor. Watchmen will be supplied, but MSNJ cannot guarantee exhibitors against loss. All valuable property should be insured by the exhibitor. MSNJ and the Committee on Scientific Exhibits neither endorse nor assume any responsibility for the contents of such exhibit.

11. *Awards:* Exhibits will be judged on the basis of originality, excellence of correlating facts, and excellence of presentation.

12. *Admission:* Admission to the Scientific Exhibits is by badge only. The general public is not admitted.

These regulations have become a part of the agreement between the exhibitor and The Medical Society of New Jersey. They have been formulated for the best interests of all concerned, and the cooperation of the exhibitors will be deeply appreciated.

THE MEDICAL SOCIETY OF NEW JERSEY

209th Annual Meeting

GARDEN STATE PARK CONVENTION CENTER, CHERRY HILL, NEW JERSEY

APPLICATION FOR SPACE IN THE SCIENTIFIC EXHIBITS

May 31-June 2, 1975

The Committee on Scientific Exhibits will furnish uniform, painted signs for each exhibit—if requested by exhibitor. Please fill in the following form carefully. (use *typewriter*, or *print*, please)

1. TITLE (Generic names only): .....

   .....

   Full Name and Degree of Exhibitor(s) .....

   .....

   City ..... State .....

   Institution (if desired) ..... City .....

   Aided by commercial or pharmaceutical company .....

   Exhibit constructed by: .....

2. DESCRIPTION OF EXHIBIT: Please give a brief statement telling the purpose of the exhibit, what it shows, and the conclusions reached—use generic names only. (This is for publication in the printed program.)

   .....

   .....

   .....

   .....

   .....

3. Is the exhibit free-standing or self-contained? .....
4. SIGN required: ..... SIGN *not* required: .....
5. Will backwall and dividers be required? (see sketch on reverse side): .....
6. SIZE OF BOOTH REQUESTED (See sketch on back) ABSOLUTE MAXIMUM: length 15′, depth 8′.

   Desired inside clear backwall (8 to 15 feet) ..... Minimum inside clear blackwall .....
7. PHOTOGRAPH OR SKETCH of exhibit should accompany this application. .....
8. Has this exhibit been shown in whole or part at any other scientific meeting? .....

   If so, when? ..... and where? .....

The undersigned agrees to abide by the regulations listed.

Name .....

Address .....

Date: ....

Return application to Francis X. Keeley, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

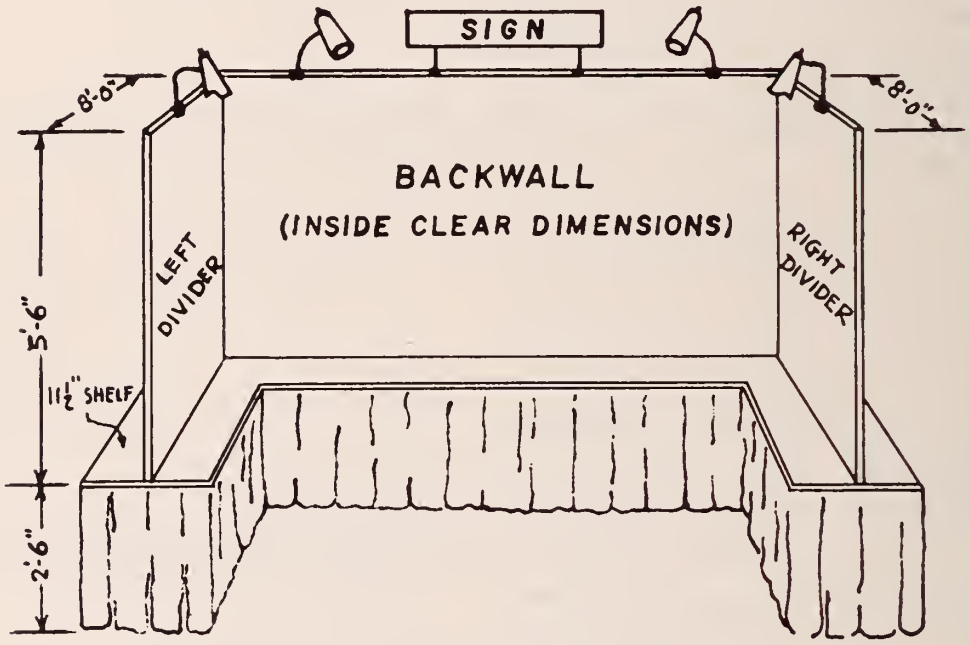
STANDARD EQUIPMENT REQUISITION FORM

Use this form only in connection with equipment to be supplied by the Committee on Scientific Exhibits. Equipment listed below will be provided at no charge to exhibitors. However, it is important that you anticipate your exact requirements in advance, as last minute changes are costly to the Society.

All scientific booths will be erected with backwall and dividers as illustrated below. Shelving and overhead lights are optional.

ILLUSTRATION OF TYPICAL BOOTH

(Booth construction: composition board covered with burlap)

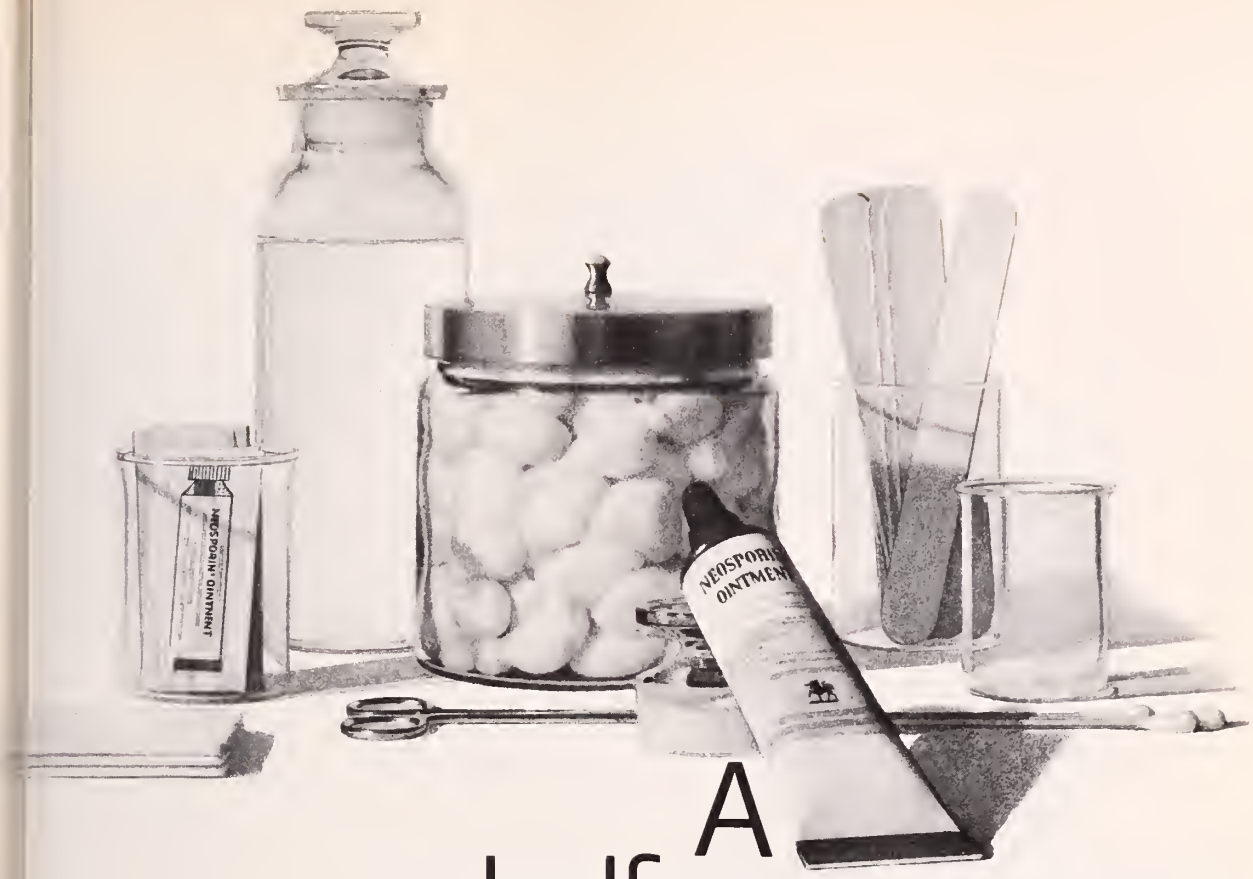


Check appropriate boxes:	left divider		backwall		right divider	
Shelving	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no
Overhead lights	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no

If your exhibit will not require backwall, or left or right dividers, please advise.

If a sign is incorporated with your exhibit, please advise, and one will *not* be ordered for you.

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM



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Use it to prevent a topical infection. Or to treat one that's already started. In either case, it's good medicine. Whether for lacerations, burns, open wounds, IV catheter or surgical aftercare. Neosporin® Ointment provides broad antibacterial coverage against common susceptible pathogens. And since it contains three antibiotics that are rarely used systemically, the risk of sensitization is reduced. Neosporin Ointment. A half-ounce of prevention. Also available in a full ounce of prevention and in convenient foil packets.

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ONS: *Therapeutically,* used as an adjunct to appropriate systemic or topical infections, primary or secondary, due to susceptible organ- n: • infected burns, skin grafts, surgical incisions, otitis externa pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • second- fected dermatoses (eczema, herpes, and seborrheic dermatitis) tic lesions, inflamed or suppurating as a result of bacterial infection. *ylactically,* the ointment may be used to prevent bacterial contamination skin grafts, incisions, and other clean lesions. For abrasions, minor cuts ds accidentally incurred, its use may prevent the development of and permit wound healing.

NDICATIONS: Not for use in the eyes or external ear canal if the eardrum ated. This product is contraindicated in those individuals who have persensitivity to any of the components.

: Because of the potential hazard of nephrotoxicity and ototoxicity omycin, care should be exercised when using this product in treating burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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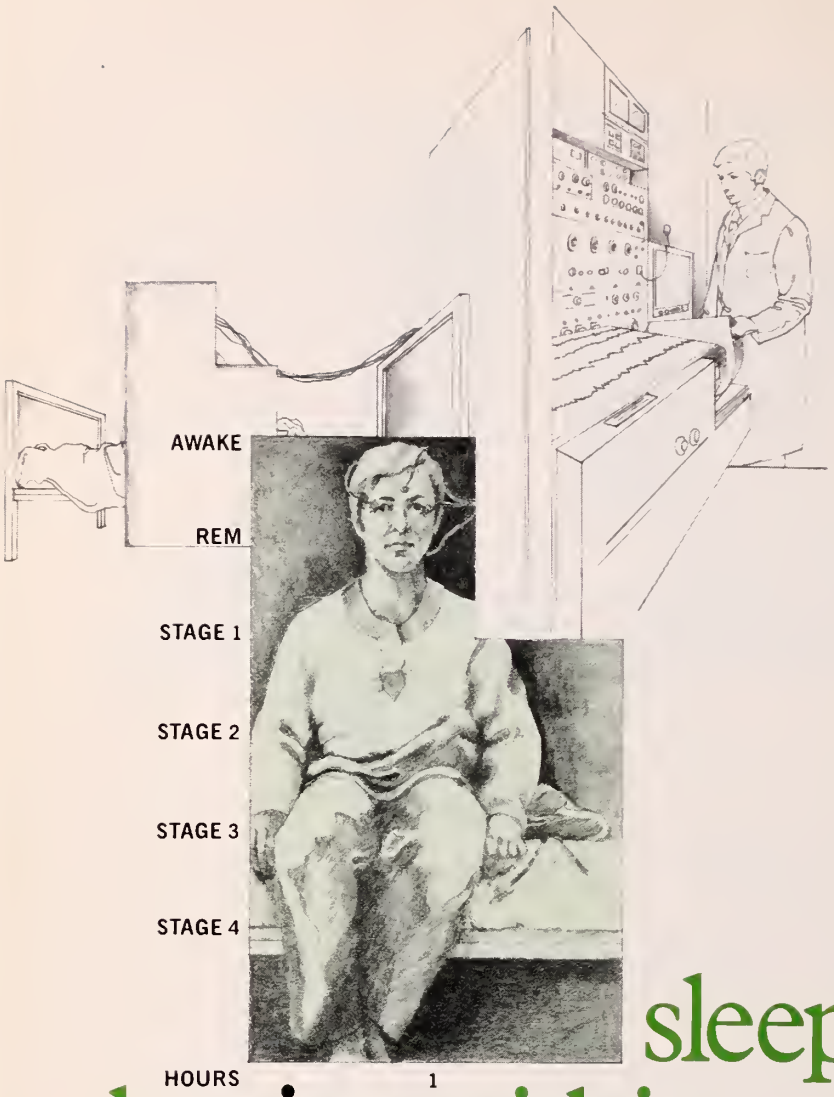


sleep begins within 17 minutes, on average...

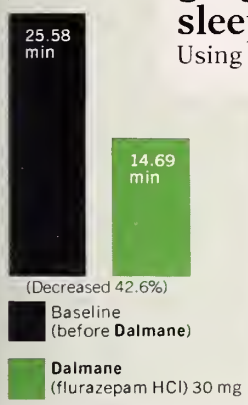
an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

)almane is generally well tolerated; morning "hang-over" has been relatively ıfrequent. While dizziness, drowsiness, lightheadedness and the like have een noted most often, particularly in the elderly and debilitated, physicians hould be aware of the possibility of more serious reactions, as noted below.

efore prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, summary of which follows:

ndications: Effective in all types of insomnia characterized by difficulty in falling asleep, equent nocturnal awakenings and/or early morning awakening; in patients with recurring ısomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful leep. Since insomnia is often transient and intermittent, prolonged administration is generally ot necessary or recommended.

ontraindications: Known hypersensitivity to flurazepam HCl.

Varnings: Caution patients about possible combined effects with alcohol and other CNS epressants. Caution against hazardous occupations requiring complete mental alertness e.g., operating machinery, driving). Use in women who are or may become pregnant only when otential benefits have been weighed against possible hazards. Not recommended for use in ersons under 15 years of age. Though physical and psychological dependence have not been eported on recommended doses, use caution in administering to ddiction-prone individuals or those who might increase dosage.

recautions: In elderly and debilitated, initial dosage should be mited to 15 mg to preclude oversedation, dizziness and/or ataxia. f combined with other drugs having hypnotic or CNS-depressant ffects, consider potential additive effects. Employ usual precautions n patients who are severely depressed, or with latent depression or uicidal tendencies. Periodic blood counts and liver and kidney unction tests are advised during repeated therapy. Observe usual recautions in presence of impaired renal or hepatic function.

dverse Reactions: Dizziness, drowsiness, lightheadedness, taggering, ataxia and falling have occurred, particularly in elderly r debilitated patients. Severe sedation, lethargy, disorientation and oma, probably indicative of drug intolerance or overdosage, have een reported. Also reported were headache, heartburn, upset tomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, hest pains, body and joint pains and GU complaints. There have lso been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of reath, pruritus, skin rash, dry mouth, bitter taste, excessive salivaion, anorexia, euphoria, depression, slurred speech, confusion, estlessness, hallucinations, and elevated SGOT, SGPT, total and irect bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been eported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg sual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Nutley, New Jersey 07110

The Role of the Detail Man

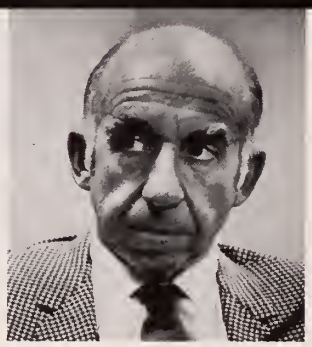
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I a very much in favor of the detail m I meet. Most of them are knowled able about the drugs they promot and can be a great help in acquai ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most c the men who visit me regularly an they in turn have become aware o my particular interests and the na ture of my practice. They, therefore, limit their discussion as muc as possible to the areas of interest to me. Since I usually see the sam representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealin with health problems in this count there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of con tact that people in a medical cente research people, and academic people have and that's in all likelih on a somewhat different level from that of the practicing physician.

Let me touch on how I person ally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent film produced by the pharmaceutical industry. When they function in thi

a Source of Information?

Yes, with certain reservations. verage sales representative great fund of information t the drug products he is re- sible for. He is usually able to er most questions fully and igently. He can also supply nts of articles that contain a deal of information. Here, exercise some caution. I usu- ccept most of the statements pinions that I find in the rs and studies which come the larger teaching facilities. s without saying that a physi- should also rely on other es for his information on macology.

ing of Sales Representatives

Ideally, a candidate for the on as a sales representative harmaceutical company d be a graduate pharmacist as a questioning mind. I don't this is possible in every case, o it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

city they are indeed useful; cularly in the fact that they minate broadly based educa- l material and serve not just ushers" of their drugs.

ther Side of the Coin

Obviously, the pharmaceuti- mpanies are not producing all aterial as a labor of love— re in the business of selling cts for profit. In this regard mbitious and improperly moti- sales representative can a negative influence on the icing physician, both by pre- g a one-sided picture of his ct, and by encouraging the itioner to depend too heavily gs for his total therapy. In ways, the salesman has often ted objective reality and mined his potential role as an tor.

dustry Responsibility

Since the detail man must be ormation resource as well as esentative of his particular naceutical company, he d be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

CLINICAL NOTES

Xeromammography in Congestive Heart Failure Mimicking Breast Carcinoma*

William E. Mattey, M.D. and Murray Seltzer, M.D.
Livingston

Skin thickening of the breasts caused by carcinoma is a well recognized entity.[1,2] Post breast irradiation, chest wall surgery, trauma, acute mastitis, primary skin diseases, and lymphatic obstruction from regional chest wall or intrathoracic lesions may cause skin thickening resembling breast carcinoma.[3] Congestive heart failure is capable of producing the same mammographic pattern as breast carcinoma.[4] The case reported here is the first instance seen in xeromammography.

A 66-year-old, diabetic female was admitted to Saint Barnabas Medical Center for dialysis for chronic renal failure and congestive heart failure (Figure 3). The patient was hospitalized for approximately three weeks when she developed mastodynia and marked pitting edema of the areolae.

Figure 3—Chest roentgenogram during congestive heart failure. Cardiomegaly with bilateral pleural effusion.

Xeromammography was performed (Figures 1A and 1B). The initial xeromammography impression was diffuse edema and skin thickening of both breasts due to congestive heart failure. The congestive heart failure responded to medical therapy, the patient was instructed to wear a brassiere for continuous support twenty-four hours per day. Following general clinical improvement, both breasts decreased in size with reduction of the diffuse edema. Xeromammography was repeated after four days (Figures 2A and 2B) and showed marked resolution of the problem as evidenced by the decreased edema.

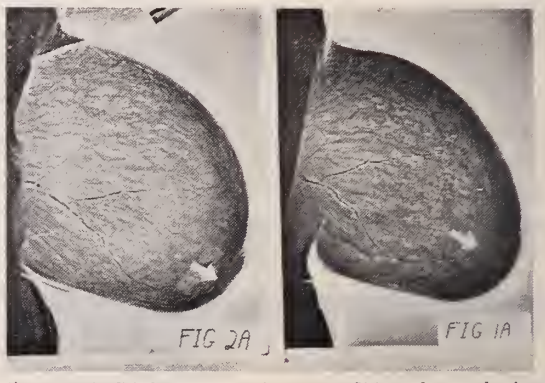


Figure 1A—Right Breast (arrow). Skin edema during circulatory failure. *Figure 2A*—Right Breast (arrow). Normal skin thickness after remission of congestive heart failure.

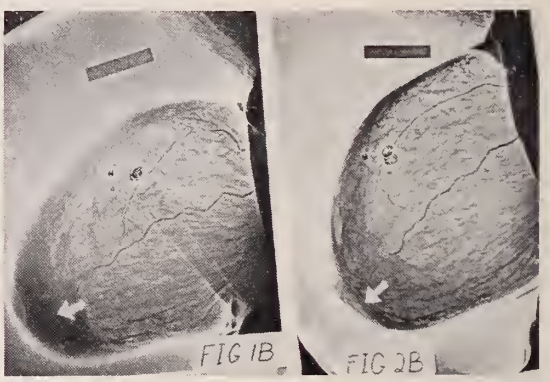


Figure 1B—Left Breast (arrow). Skin edema during circulatory failure. *2B*—Left Breast (arrow). Normal skin thickness after remission of congestive heart failure.

This case, as well as the cases reported by Stolz and Morrish, however, do suggest the mammographic pattern in edema of the breasts due to congestive heart failure is indistinguishable from that of other causes.[3] In our case, bilateral edematous breast skin thicken-

*From the departments of radiology and surgery, Saint Barnabas Medical Center, Livingston, New Jersey, where Dr. Mattey is Director of Radiology and Dr. Seltzer is Attending Surgeon.

ing during circulatory failure was documented by xeromammography which was repeated following remission from dependent edema with cardiac compensation. Xeromammography offers an excellent method of illustrating the breast skin thickening due to "edge-enhancement" effect specific to xeroradiography.[5]

References

1. Berger SM: Inflammatory carcinoma of the breast. *Am J Roentgenol Rad Ther Nucl Med* 88:1109-1116, 1962.

2. Egan RL: *Mammography*. Springfield, Illinois, Charles C Thomas Publisher, 1964.

3. Morrish HF: The significance and limitations of skin thickening as a diagnostic sign in mammogrpahy. *Am J Roentgenol Rad Ther Nucl Med* 96:1041-1045, 1966.

4. Stolz JL, *et al:* Breast carcinoma simulation. *JAMA* 229:682-683, 1974.

5. Wolfe JN: Xeroradiography: Image content and comparison with film roentgenographs. *Am J Roentgenol Rad Ther Nuc Med* 117:690-695, 1973.

LETTERS TO THE JOURNAL

Questionable "Standard" Therapy

August 29, 1974

Dear Sir:

In commenting upon the article on "the use of propranalol . . . in the treatment of essential hypertension," *The Journal,* MSNJ, August 1974, I do not mean to question its conclusion that "the use of propranalol is ideal in some hypertensive patients who have been poorly responsive to standard therapy." But I do take issue with the protocol and the implied conception of what constitutes a "standard" regimen for the treatment of this disease.

Scrutiny of the author's list of 17 involved patients immediately exposes what appears to me to be a hodge-podge of many widely different "previous" drug therapies to which the patients "have been poorly responsive" and none of which impresses me as being anything even closely resembling what I believe to be a reasonably "standard" regime.

For extreme examples taken from the list, I wonder what kind of "standard" regime is the sole prescription of "Aldomet® 25 mg (sic) (or 250 mg) Q-A.M." for 174/102 or for any hypertensive patient. Nor can I, by any stretch of the imagination, conceive of "Ser-Ap-Es® T-I-D" as a "standard" therapy. Nor can I recognize the sole prescription of "Ismelin® 25 mg or 37.5 mg Q-A.M." as even remotely resembling a "standard" therapy.

In connection with the article in question, and in general, I do not view such treatment as "standard," but rather include it in relation to the estimated 3,000,000 hypertensives currently reported to be receiving inadequate therapy.

It is my accumulative and amalgamated concept, based upon recent authoritative literature, that a "standard" (recommended, acceptable) regime for the treatment of essential hypertension begins with a thiazide as the keystone of therapy, to be increased up to its recommended maximum dose, if necessary, either alone, or, if indicated, with a second drug, which in turn should be increased to its recommended maximum dose, if necessary, before adding a third drug, which in turn should be increased to its recommended maximum dose, if necessary, before adding a fourth drug, and so on. In sequence, then, as deemed indicated, come reserpine, methyldopa, hydralazine, guanethidine, and aldactone, but not necessarily in that order, and, of course, each drug quantitatively tailored to the needs and tolerance of the individual patient.

With regard to the protocol, it is stated that, in the cases cited, "hydralazine . . . was com-

bined with propranalol." But the author's table indicates that, in addition to the hydralazine, 16 of the 17 cases were also given various amounts of one or more of Aldactone,® Serpasil,® Esidrix,® Ismelin,® and Esimil.® In only one of the cases was hydralazine the only drug given with the propranalol, and in two cases, no hydralazine was given at all.

And in the summary, it is stated that the 17 previous failures "were treated with the addition of oral propranalol," when, according to the listing, the previously ineffective drug regimes were markedly changed in 15 of the cases, and in one case the propranalol which the patient had already been getting was dropped. Thus, by changing the "previous" drug regimes while adding propranalol, there was effectively eliminated any kind of control as related to the additive effects of propranalol, thereby, I think, actually nullifying the described project.

Consequently, while I do not debate the article's conclusion, which echoes other reports, I do not accept the article's procedures upon which the author bases this conclusion.

With the grim consensus that 3,000,000 hypertensives (50 percent of the 6,000,000 currently under treatment) are not receiving adequate therapy, I question the assertion that the patients involved had previously had "standard antihypertensive therapy" and fear that it may be misleading and contributory to the perpetuation of sub-standard therapy. And, in view of my convictions, I must add that I am skeptical of the "Present Drugs" regimes as well.

While it is certainly agreed that an acceptable, relatively low salt diet is still discriminatingly recommended, it is also recognized that, with the advent and proper use of the thiazides and other diuretics with their natriuretic effectiveness, the unpalatable and rarely-followed " 'absolute' restriction of . . . salt intake" has long ago lost its earlier distinction of being a "critical need."

(Signed) Jules Cooper, M.D.

Caution in School Medications

September 25, 1974

Dear Sir:

I have some comments on the editorial entitled, "Dispensing Medications in School" which appeared in *The Journal* of September 1974.

It has been my experience that there is already too much opportunity for interference of treatment prescribed by physicians by bureaucratic, short-sighted, dictatorial school authorities.

This is particularly true for routine medications prescribed for chronic conditions. In such instances (e.g. chronic allergic asthma), it has usually required much patient educational efforts by the physician to have parent and child-patient recognize the indications and need for prompt (and routine) medication. Too often school authorities think they know better!—that exertional asthma after gym (for example) is psychosomatic and requires no medication.

Also, not infrequently, the "*one* responsible person" is absent, busy elsewhere, or otherwise not available to the detriment of the patient's health.

Therefore, as a preamble to any set of guidelines, school authorities should be warned of the probable seriousness of interfering with instructions from physicians or any unauthorized deviation from prescription legends, or medication suggested and carried by the patient.

(Signed) F. A. Pflum, M.D.

209th Annual Meeting

May 31—June 3

Scientific Exhibit Application, p. 877

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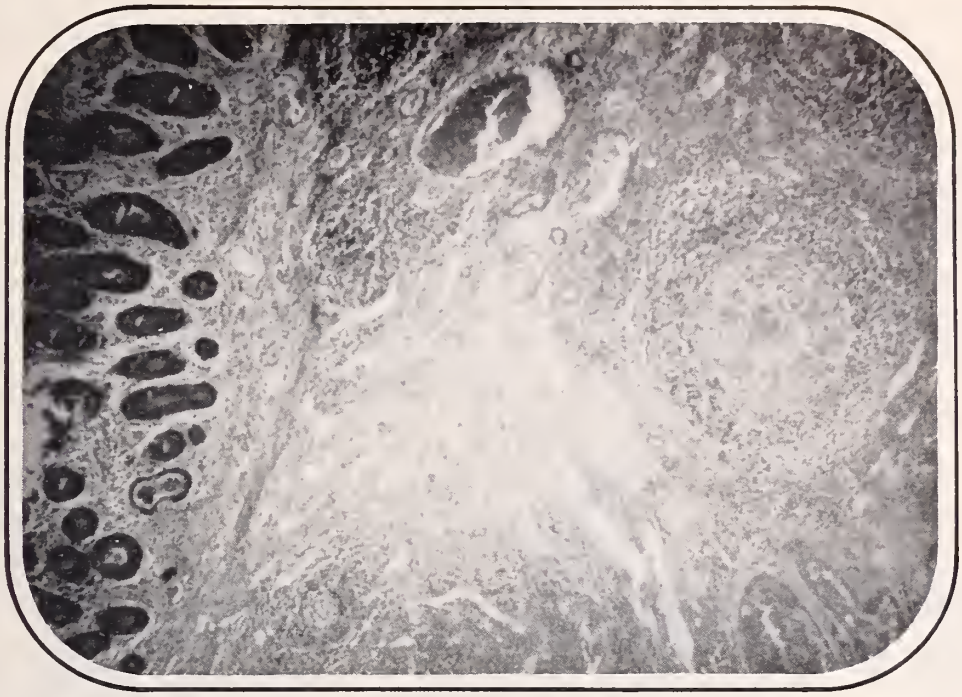

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*Granulomatous colitis is revealed in this photomicrograph. Diagnostic signs show full thickn
involvement of the bowel wall, including mucosa and muscularis, by a granulomatous
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generally limited to the mucosa.

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Ascorbic Acid .....150 mg.	Ascorbic Acid .....150 mg.	Thiamine HCL (B-1) .... 25 mg.
Thiamine HCL (B-1) .... 25 mg.	Thiamine HCL (B-1) .... 25 mg.	Riboflavin (B-2) ..... 2 mg.
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ANNOUNCEMENTS

Practical Cardiology for the Clinician

A course in the practical management of cardiac problems seen by the practicing physician will be presented by the Medical College of Pennsylvania on Thursdays—7 to 10 p.m.—from October 24, 1974 through January 16, 1975 at the College (Kaiser Auditorium, 3300 Henry Avenue, Philadelphia 19129). Utilizing case presentations, lectures, audiovisual techniques, and question and answer periods, emphasis will be placed on new and current concepts in the diagnosis and treatment of the most frequently encountered cardiovascular disorders. Registration fee is $125. Hour-for-hour credit will be granted in Category I of the AMA Physicians' Recognition Award. For additional information, please write to Gerald H. Escovitz, M.D., Associate Dean of the College at the above address.

Current Topics in Psychiatry

The Fair Oaks Hospital in Summit announces the following programs in the 1974-1975 series on current topics in psychiatry. Dates and topics of subsequent sessions will be announced in future issues of *The Journal.*

Nov. 6—Meditation as an Adjunct to Psychotherapy
Nov. 20—Diagnosis in the Anemic Patient
Nov. 26—Migrant Adjustment of Refugees
Dec. 4—Medical-Legal Aspects of Medicine
Jan. 8—New Developments in Scanning

Sessions are held from 3 to 4:30 p.m. in the Conference Room at the Hospital (19 Prospect Street). Granville L. Jones, M.D., Director of Research and Education at Fair Oaks, will be moderator and further information is available by writing directly to him.

The programs are cosponsored by the Academy of Medicine and are accredited for Category I of the AMA Physician's Recognition Award.

Pulmonary Disease Lectures

The Veterans Administration Hospital in East Orange and the New Jersey Medical School, CMDNJ are cosponsors of a 1974-1975 series of lectures in pulmonary diseases, to be held on Wednesdays at 11:30 a.m. at the Veterans Administration Hospital, East Orange, on the dates indicated.

November 20	Histoplasmosis
December 18	Emergency Pulmonary Care
January 15	Rifampin, Tuberculin
February 19	Chemical Control of Respiration
March 19	Cor Pulmonale
April 16	Infectiousness of Tuberculosis before and after Chemotherapy
May 14	Respiratory Failure

Training Program for Emergency Department Physicians

In cooperation with the Inter-Agency Commission on Emergency Medical Care, MSNJ will sponsor a training program for emergency department and other interested physicians in each of the Society's Judicial Districts from 9 a.m. to 4 p.m. on three successive Wednesdays, as indicated. (A similar course has been arranged for nurses at Morristown Memorial, Dover General, St. Peter's (New Brunswick), Jersey Shore (Neptune), and Burlington County Hospitals.)

The series consists of lectures and demonstrations and the subjects included cover resuscitation of the severely injured patient, burns, emergencies of the chest and abdomen, musculoskeletal injuries, the unconscious patient, and psychiatric emergencies.

1st District	November 20 December 4 December 11	St. Elizabeth Hospital Elizabeth
2nd District	December 11 December 18 January 8	St. Joseph's Medical Center Paterson
3rd District	January 29 February 5 February 12	St. Francis Hospital Trenton

4th District	January 8 January 15 January 22	Monmouth Medical Center Long Branch
5th District	November 20 December 4 December 11	The Cooper Hospital Camden

Each course is limited to 100 persons and registration is required. Applications were mailed to each physician last month. The programs have been approved for Category I, AMA Physician's Recognition Award. For further information, please communicate with Jack R. Karel, M.D., Chairman, Inter-Agency Commission on Emergency Medical Care, 115 North Avenue, Hillside, New Jersey 07205.

Neuroscience Unit Conferences

The Neuroscience Unit of the Bergen Pines County Hospital in Paramus announces the following programs in its series of conferences. Additional programs will be listed in a later issue of *The Journal.*

November 25	Neurology-Neurosurgery Conference Warren Foer, M.D.
December 2	Neuropsychiatric Aspects of Aging Louis Chodosh, M.D.
December 9	Neurology-Neurosurgery Conference Warren Foer, M.D.
December 16	Basic Principles of Cerebral Palsy Harvey Merless, M.D.
January 6	Neurology-Neurosurgery Conference Warren Foer, M.D.
January 13	Seizure Disorders Michael Gruber, M.D.

Sessions are held from 11:30 a.m. to 12:30 p.m. in the auditorium at the hospital. Accreditation for Category I of the AMA Physicians' Recognition Award is pending. For additional information, please communicate with Leonard J. Lyon, M.D., Codirector of Medical Education at Bergen Pines County Hospital Paramus 07652.

Pediatric Behavior Management Conference

On February 21 and 22, 1975, the Department of Pediatrics of the University of Miami School of Medicine will sponsor a conference on pediatric behavior management. Pediatricians and psychologists will discuss such topics as toilet training and eliminative disorders, emotional behavioral problems, and aspects of psychophysiological disorders in childhood. Emphasis will be on a social learning approach and the cooperation of pediatricians and behavioral scientists in treatment. Information as to fee and registration is available from the Division of Continuing Medical Education, University of Miami Florida 33152.

Radiology Conference in Aspen

From March 3 to 7, 1975, the Institute for Humanistic Studies in Aspen, Colorado, will be the site of a conference designed for physicians and scientists interested in diagnostic radiology, nuclear medicine, and radiation therapy. Included will be discussion of the impact of clinical and technological advances on radiologic practice and refresher courses in radiology subdivisions, with independent diagnostic, nuclear medicine, and therapy sessions. Previewed instructive cases illustrating these topics will be presented. For further information please write to Maurice O'Connor, M.D. Conference Director, Division of Radiology, Denver General Hospital, Denver, Colorado 80204.

Mock Surgery Boards

During May 1975, the Department of Surgery of the New Jersey Medical School, CMDNJ, will conduct the second mock board examinations—Part I (written) on May 10 and Part II (oral) on May 24. Part I will consist of two-hundred multiple choice questions that closely imitate the examination of the American Board of Surgery. Part II will cover pathology and oral examinations conducted by three panels of examiners. Results are strictly confidential and are revealed only to the candidates and to their directors of surgery. These examinations are recommended for residents (preferably third or fourth years) and for others who have completed their training and are preparing for the surgery boards. Applica-

tions must be received by March 15, 1975. For further information, please write to Eric J. Lazaro, M.D., Martland Hospital Unit, 65 Bergen Street, Newark, New Jersey 07107.

Preceptorships for Practicing Physicians

The Medical College of Pennsylvania offers a program of preceptorships for practicing physicians tailored to the continuing medical education needs of individual physicians. Each program is designed to afford the practitioner an opportunity to update present skills and learn new patient techniques. Sessions are held at the College (3300 Henry Avenue, Philadelphia 19129) and include clinics, rounds, lectures, and seminars. Selections may be made from the areas of anesthesiology, internal medicine, neurology, obstetrics-gynecology, pathology, pediatrics, psychiatry, radiology, and surgery and may be arranged for half-days for 16 weeks ($300), full-days for 16 weeks ($400), a two-week block ($350), or a one-month block ($600). The programs are acceptable for Category I of the AMA Physicians' Recognition Award. American Academy of General Practice credit is also available. For further information, please write to Gerald H. Escovitz, M.D., Associate Dean of the College at the above address.

Training Programs in Pediatrics and Obstetrics

The University of California School of Public Health at Berkeley announces 9 to 21-month training programs for pediatricians and obstetricians in maternal and child health, the school age child, family planning, child development, the handicapped child, care of mothers and children, and perinatology. Purpose of the programs is to prepare physicians for leadership position in medical schools, health education departments, and hospital and community service programs. Fellowships are available, and applications are now being accepted for September of 1975. Inquiries should be addressed to Helen M. Wallace, M.D., Professor of Maternal and Child Health, University of California School of Public Health, Berkeley, California 94720.

209th ANNUAL MEETING, MSNJ

Garden State Convention Center

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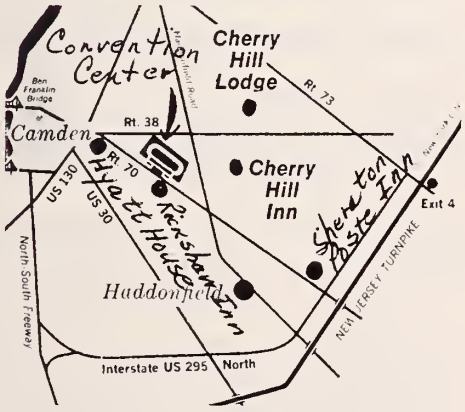

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MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

Nov.

9 **Surgical Symposium**
9-12 noon—Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and Academy of Medicine)

9 **Annual Meeting—American Academy of Pediatrics**
9 a.m.-3 p.m.—Governor Morris Inn, Morristown
(Sponsored by American Academy of Pediatrics and Academy of Medicine)

9 **Orthopedic Surgery**
16 8:30 a.m.—Martland Hospital, Newark
23 *(Sponsored by CMDNJ, New Jersey Medical*
30 *School and Academy of Medicine)*

9 **Basic Science for Surgeons**
16 10 a.m.-12 noon—Martland Hospital, Newark
23 *(Sponsored by CMDNJ, New Jersey Medical*
30 *School, and Academy of Medicine)*

11 **Distinguished Lectures in Surgery**
18 4-5 p.m.—Martland Hospital, Newark
25 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

12 **Differential Diagnosis of Arthritis**
8 p.m.—Paul Kimball Hospital, Lakewood
(Sponsored by Academy of Medicine)

12 **Case Presentation and Discussion**
8 p.m.—White Laboratories, Schering Corporation
(Sponsored by New Jersey Dermatological Society and Academy of Medicine)

12 **Clinical Immunology**
11 a.m.—Margaret Hague Maternity Hospital, Jersey City
(Sponsored by Academy of Medicine)

13 **Acute Leukemia**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital and Academy of Medicine)

13 **Social Psychiatry and Public Health**
1 p.m.—Ancora Psychiatric Hospital, Hammonton
(Sponsored by Ancora Psychiatric Hospital)

13 **Clinical Endocrinology**
20 3:30 p.m.—Martland and Beth Israel Hospitals,
27 Newark, and VA Hospital, East Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

13 **Seminar in Group and Family Therapies**
20 8 p.m.—Englewood Hospital, Englewood
27 *(Sponsored by Academy of Psychoanalysis of New Jersey and Academy of Medicine)*

13 **Distinguished Lectures in Neuroscience**
20 10:30-11:30 a.m.—VA Hospital, East Orange
27 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

13 **Early Complications of Pregnancy**
20 **Hypothalamic Releasing Factors**
27 **Chemotherapy of Cancer**
27 **Disorders of Lower Esophagus**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

13 **1974-75 Medical Lecture Series**
20 9-11 a.m.—Riverview Hospital, Red Bank
27 *(Sponsored by Riverview Hospital and Academy of Medicine)*

13 **Myocardial Infarction—Critically Ill Patient**
2 p.m.—Cherry Hill Medical Center, Cherry Hill
(Sponsored by Academy of Medicine)

13 **Symposium on Emergency Medicine**
14 Cherry Hill Inn, Cherry Hill
(Sponsored by New Jersey Chapter, ACS)

13 **Hyperlipidemia**
8:30-10 p.m.—East Orange General Hospital
(Sponsored by East Orange General Hospital and Academy of Medicine)

13 **Death and Dying**
9-10:30 p.m.—Veterans Administration Hospital, East Orange
(Sponsored by Lewis H. Loeser Memorial Foundation and Academy of Medicine)

13 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)

13 **Regional Meeting, American College of Physicians**, Rutgers Medical School, Piscataway

14 **Diagnostic Ultrasound**
8-9 p.m.—Mount Holly Medical Center
(Sponsored by Burlington County Medical Society and Academy of Medicine)

14 **Practice in Essex County**
8:30 p.m.—Harvard Green Motor Inn, East Orange
(Sponsored by Essex County Medical Society and Academy of Medicine)

15 **Outpatient Care of the Asthmatic**
11:30 a.m.-12:30 p.m.—Paterson General Hospital, Paterson
(Sponsored by Academy of Medicine and New Jersey Allergy Society)

15 **Proper Use of Antibiotics**
12 noon—Freehold Area Hospital, Freehold
(Sponsored by Academy of Medicine)

16 **Family Planning and Human Sexuality**
9:30 a.m.-12:30 p.m.—Monmouth Medical Center, Long Branch
(Sponsored by Planned Parenthood of Monmouth County and Academy of Medicine)

16 **Diabetes Today and Tomorrow**
9:30 a.m.-5 p.m.—St. Michael's Medical Center, Newark
(Sponsored by N.J. Diabetes Assn. and AAFP)

19 **Medical-Legal Aspects of Surgery and Anesthesiology**
6-9 p.m. (dinner meeting)—Ramada Inn, Clark
(Sponsored by New Jersey Society of Anesthesiologists and Academy of Medicine)

19 **Diagnosis in Anemic Patient**
11:30 a.m.—St. Mary's Hospital, Orange
(Sponsored by Academy of Medicine)

20 **Difficult Diabetic Patient**
10 a.m.—St. James Hospital, Newark
(Sponsored by Academy of Medicine)

20 **Congestive Heart Failure**
1 p.m.—Trenton Psychiatric Hospital, Trenton
(Sponsored by Academy of Medicine)

20 **Difficut Diabetic Patient**
1:30 p.m.—John E. Runnells Hospital, Berkeley Heights

20 **Drug Addiction**
3 p.m.—Fair Oaks Hospital, Summit
(Sponsored by Academy of Medicine)

20 **Histoplasmosis**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

20 **Current Topics in Psychiatry**
3-4:30 p.m.—Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)

20 **Diagnosis in Anemic Patient**
3 p.m.—Fair Oaks Hospital, Summit
(Sponsored by Academy of Medicine)

20 **Training Program for Hospital Emergency Department Physicians**
10 a.m.-3:30 p.m.—The Cooper Hospital, Camden
(Sponsored by Interagency Commission on Emergency Medical Care, The Cooper Hospital, and the Academy of Medicine)

20 **Depression**
10 a.m.-4 p.m.—Camden County Psychiatric Hospital, Lakeland
(Sponsored by Camden County Psychiatric Hospital and the Academy of Medicine)

20 **Joint Monthly Sessions of Clinical Interest**
7-9 p.m.—VA Hospital, East Orange
(Sponsored by Academy of Medicine, New Jersey Medical School, CMDNJ, and VA Hospital, East Orange)

20 **Pulmonary Disease**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Spsnsored by Academy of Medicine and New Jersey Medical School, CMDNJ)

21 **Thyroid Diseases**
10 a.m.—Memorial General Hospital, Union
(Sponsored by Academy of Medicine)

21 **Congenital Bone Anomalies (Pediatric)**
7:15-10:15 p.m.—Hospital Center at Orange
(Sponsored by Radiology Society of New Jersey and Academy of Medicine)

22 **Hospital Care of the Asthmatic including Respiratory Failure**
11:30 a.m.-12:30 p.m.—Paterson General Hospital, Paterson
(Sponsored by New Jersey Allergy Society and Academy of Medicine)

23 **Hormonal Therapy**
St. Barnabas Medical Center, Livingston
(Sponsored by AAFP and St. Barnabas Medical Center)

26 **Drug Addiction**
11 a.m.—Greystone Park Psychiatric Hospital, Greystone
(Sponsored by Academy of Medicine)

26 **Hyperlipidemia**
8-10 p.m. —Perona Farms, Andover
(Sponsored by Sussex County Medical Society and Academy of Medicine)

26 **Clinical Endocrinology**
9 p.m.—William B. Kessler Memorial Hospital, Hammonton
(Sponsored by Academy of Medicine)

27 **Anti-arrhythmic Drugs**
9 a.m.—Holy Name Hospital, Teaneck
(Sponsored by Holy Name Hospital and Academy of Medicine)

29 **Insect Allergy**
11:30 a.m.-12:30 p.m.—Paterson General Hospital, Paterson
(Sponsored by New Jersey Allergy Society and Academy of Medicine)

Dec.

2 **Neurology**
8 p.m.—Community Memorial Hospital, Toms River
(Sponsored by Academy of Medicine)

2, 9, 16, 23, 30 **Distinguished Lectures in Surgery**
4-5 p.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

4 **Fluid and Electrolyte Imbalance**
10 a.m.—St. James Hospital, Newark
(Sponsored by Academy of Medicine)

4 **The Critically Ill Patient—Extreme Infection**
2 p.m.—Christ Hospital, Jersey City
(Sponsored by Academy of Medicine)

4 **Medical-Legal Aspects of Medicine and Surgery**
3 p.m.—Fair Oaks Hospital, Summit
(Sponsored by Academy of Medicine)

4 **Psychiatry**
3-4:30 p.m.—Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)

4 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

4 **Monthly Meeting**
8-10 p.m.—Hackensack Hospital, Hackensack
(Sponsored by New Jersey Gastroenterological Society and Academy of Medicine)

4 **Group and Family Therapies**
8 p.m.—Englewood Hospital, Englewood
(Sponsored by Academy of Psychoanalysis of New Jersey and Academy of Medicine)

4 **Clinical Endocrinology**
11 3:30 p.m.—Martland Hospital, Newark, Beth
18 Israel, and VA Hospital, East Orange (varies)
(Sponsored by Middlesex General Hospital and Academy of Medicine)

4 **Office Proctology**
11 **Androgen and Virilizing Syndromes**
18 **Mineralocorticoid Hypertension**
9-11 a.m.—Middlesex General Hospital, New Brunswick

4 **1974-75 Lecture Series**
11 9-11 a.m.—Riverview Hospital, Red Bank
18 *(Sponsored by Riverview Hospital and Academy of Medicine)*

4 **Distinguished Lectures in Neuroscience**
11 10:30-11:30 a.m.—VA Hospital, East Orange
18 *(Sponsored by New Jersey Medical School, CMDNJ, East Orange VA Hospital, and Academy of Medicine)*

5 **Clinical Nephrology**
12 4-5 p.m.—Martland Hospital Unit, Newark
19 *(Sponsored by New Jersey Medical School,*
26 *CMDNJ, and Academy of Medicine)*

7 **Annual Meeting, New Jersey Chapter, ACS**
10 a.m.-5 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by American College of Surgeons, New Jersey Chapter, and Academy of Medicine)

7 **Basic Science for Surgeons**
14 10 a.m.-12 noon—Martland Hospital, Newark
21 *(Sponsored by CMDNJ, New Jersey Medical*
28 *School, and Academy of Medicine)*

7 **Orthopedic Surgery**
14 8:30 a.m.—Martland Hospital, Newark
21 *(Sponsored by CMDNJ, New Jersey Medical*
28 *School, and Academy of Medicine)*

10 **Chemotherapy of Malignant Disease**
10:30 a.m.—North Hudson Hospital, Weehawken
(Sponsored by Academy of Medicine)

11 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)

12 **Diagnostic Radiology**
8-10 p.m.—Helene Fuld Hospital, Trenton
(Sponsored by Diagnostic Radiology Section of Southern New Jersey and Academy of Medicine)

12 **Current Burn Treatment**
12:15 p.m.—Zurbrugg Memorial Hospital, Riverside
(Sponsored by Academy of Medicine)

16 **Fluid and Electrolyte Imbalance**
8 p.m.—Irvington General Hospital, Irvington
(Sponsored by Academy of Medicine)

16 **Differential Diagnosis of Arthritis**
11:30 a.m.—Helene Fuld Hospital, Trenton
(Sponsored by Academy of Medicine)

17 **Fluid and Electrolyte Imbalance**
11:30 a.m.—St. Mary's Hospital, Orange
(Sponsored by Academy of Medicine)

17 **Emergencies in Psychiatric Practice**
11 a.m.—Greystone Park Psychiatric Hospital, Greystone
(Sponsored by Academy of Medicine)

17 **Cardiac Arrhythmias**
Hospital Center at Orange, Orange
(Sponsored by Academy of Medicine)

18 **Emergency Pulmonary Care**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

18 **Proper Use of Antibiotics**
10 a.m.—St. James Hospital, Newark
(Sponsored by Academy of Medicine)

18 **Joint Monthly Sessions of Clinical Interest**
7-9 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)

24 **Hypersensitive Lung Disease**
10 a.m.-12 noon—Perth Amboy General Hospital, Perth Amboy
(Sponsored by Allergy Society of New Jersey and Academy of Medicine)

Jan.
2 **Clinical Nephrology**
9 4-5 p.m.—Martland Hospital Unit, Newark
16 *(Sponsored by CMDNJ, New Jersey Medical*
23 *School, and Academy of Medicine*
30

4 **Orthopedic Surgery**
11 8:30 a.m.—Martland Hospital, Newark
18 *(Sponsored by CMDNJ, New Jersey Medical*
25 *School, and Academy of Medicine)*

4 **Basic Science for Surgeons**
11 10 a.m.-12 noon—Martland Hospital, Newark
18 *(Sponsored by CMDNJ, New Jersey Medical*
25 *School, and Academy of Medicine)*

6 **Diagnostic Radiology**
8-10 p.m.—Hunterdon Medical Center, Flemington
(Sponsored by Diagnostic Radiology Section of Southern New Jersey and Academy of Medicine)

6 **Distinguished Lectures in Surgery**
13 4-5 p.m.—Martland Hospital, Newark
20 *(Sponsored by CMDNJ, New Jersey Medical*
27 *School, and Academy of Medicine)*

8 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by New Jersey Radiological Society and Academy of Medicine)

8 **Proper Use of Blood Gases**
10 a.m.—St. James Hospital, Newark
(Sponsored by Academy of Medicine)

8 **New Developments in Scanning**
3 p.m.—Fair Oaks Hospital, Summit
(Sponsored by Academy of Medicine)

8 **Advances in Medicine**
15 9:30-11 a.m.—Bergen Pines County Hospital,
22 Paramus
29 *(Sponsored by Bergen Pines County Hospital and Academy of Medicine)*

15 10:30-11:30 a.m.—VA Hospital, East Orange
22 *(Sponsored by CMDNJ, New Jersey Medical*
29 *School, VA Hospital at East Orange, and Academy of Medicine)*

8 **1974-75 Medical Lecture Series**
15 9-11 a.m.—Riverview Hospital, Red Bank
22 *(Sponsored by Riverview Hospital and the*
29 *Academy of Medicine)*
8 **Distinguished Lectures in Neuroscience**

8 **Drug Management of Coronary Arterial Disease**
15 **Portal Hypertension**
22 **Inflammatory Bowel Disease**
29 **Common Disease of Travelers**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

8 **Clinical Endocrinology**
15 3:30 p.m.—Martland Hospital, Newark Beth
22 Israel, and VA Hospital, East Orange (varies)
29 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

9 **Medical Care in the Emergency Room**
1 p.m.—Ancora Psychiatric Hospital, Hammonton
(Sponsored by Academy of Medicine)

10 **Chronic Lung Disease**
11:30 a.m.—Helene Fuld Hospital, Trenton
(Sponsored by Academy of Medicine)

10 **Portal Hypertension**
12 noon-4:30 p.m.—Hamilton Hospital, Trenton
(Sponsored by Hamilton Hospital)

14 **Renal Failure**
8 p.m.—Paul Kimball Hospital, Lakewood
(Sponsored by Paul Kimball Hospital and Academy of Medicine of New Jersey)

14 **Cutaneous Manifestations of Systemic Disease**
8 p.m.—White Laboratories, Schering Corporation
(Sponsored by New Jersey Dermatology Society and Academy of Medicine)

14 **Fluid and Electrolyte Imbalance**
10:30 a.m.—North Hudson Hospital, Weehawken
(Sponsored by Academy of Medicine)

15 **Joint Monthly Sessions of Clinical Interest**
7-9 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)

15 **Proper Use of Antibiotics**
2 p.m.—Cherry Hill Medical Center, Cherry Hill
(Sponsored by Academy of Medicine)

15 **Neurology**
1 p.m.—Trenton Psychiatric Hospital, Trenton
(Sponsored by Academy of Medicine)

15 **Rifampin, Tuberculin**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

15 **Clinical Interpretation of Diagnostic Laboratory**
22 **Tests**
29 3:30-5:30 p.m.—Rutgers Medical School, CMDNJ, Piscataway
(Sponsored by CMDNJ, Rutgers Medical School and Academy of Medicine)

17 **Alcoholism**
9 a.m.—St. Elizabeth Hospital, Elizabeth
(Sponsored by Academy of Medicine)

20 **Medical-Legal Aspects of Medicine and Surgery**
8 p.m.—Irvington General Hospital, Irvington
(Sponsored by Academy of Medicine)

21 **Laboratory Interpretations**
11:30 a.m.—St. Mary's Hospital, Orange
(Sponsored by Academy of Medicine)

21 **Chest Case Conferences**
7:30 p.m.—VA Hospital, East Orange
(Sponsored by New Jersey Thoracic Society and Academy of Medicine)

21 **Cardiac Surgery and Anesthesiology**
6-9 p.m. (dinner meeting)—Ramada Inn, Clark
(Sponsored by New Jersey Society of Anesthesiologists and Academy of Medicine)

23 **Coronary Arteriography: Part I**
7:15-10:15 p.m.—Hospital Center at Orange
(Sponsored by Radiology Society of New Jersey and Academy of Medicine)

24 **Gastrointestinal Bleeding**
12:15 p.m.—Zurbrugg Memorial Hospital, Riverside
(Sponsored by Academy of Medicine)

28 **Neurology**
11 a.m.—Perth Amboy General Hospital, Perth Amboy
(Sponsored by Academy of Medicine)

28 **Breast Cancer**
8 p.m.—Warren Hospital, Phillipsburg
(Sponsored by Academy of Medicine)

Feb.

1 8 15 22 **Orthopedic Surgery**
8:30 a.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

1 8 15 22 **Basic Science for Surgeons**
4-5 p.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

3 10 17 24 **Distinguished Lectures in Surgery**
4-5 p.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

3 **Practical Dermatology**
8 p.m.—Community Memorial Hospital, Toms River
(Sponsored by Academy of Medicine)

5 **Neurology**
3 p.m.—Fair Oaks Hospital, Summit
(Sponsored by Academy of Medicine)

5 **Albert Siegel Symposium—Liver Disease**
2-5 p.m.—St. Barnabas Medical Center, Livingston
(Sponsored by New Jersey Gastroenterological Society and Academy of Medicine)

5 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 12 19 26 **Clinical Endocrinology**
3:30 p.m.—Martland Hospital, Newark Beth Israel, and VA Hospital, East Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 **Common Protozoal and Fungal Infections**
12 **Future of Allergy**
19 **Hemostasis**
26 **Hypercalcemia and Hyperparathyroidism**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

5 12 19 26 **1974-75 Medical Lecture Series**
9-11 a.m.—Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and Academy of Medicine)

5 12 19 26 **Clinical Interpretation of Diagnostic Laboratory Tests**
3:30-5:30 p.m.—Rutgers Medical School, CMDNJ, Piscataway
(Sponsored by CMDNJ, Rutgers Medical School and Academy of Medicine)

5 12 19 26 **Distinguished Lectures in Neuroscience**
10:30-11:30 a.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)

6 13 20 27 **Clinical Nephrology**
4-5 p.m.—Martland Hospital Unit, Newark
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

11 **Genetic Disorders**
8 p.m.—White Laboratories, Schering Corporation
(Sponsored by New Jersey Dermatological Society and Academy of Medicine)

12 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and the Academy of Medicine)

12 19 26 **Advances in Medicine**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital and Academy of Medicine)

18 **Medical-Legal Aspects of Medicine and Surgery**
11:30 a.m.—St. Mary's Hospital, Orange
(Sponsored by Academy of Medicine)

18 **Laboratory Interpretations**
12 noon—Hospital Center at Orange
(Sponsored by Academy of Medicine)

19 **Proper Use of Antibiotics**
1 p.m.—Trenton Psychiatric Hospital, Trenton
(Sponsored by Academy of Medicine)

19 **Hypertension**
1:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(Sponsored by Academy of Medicine)

19 **Joint Monthly Sessions of Clinical Interest**
7-9 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, VA Hospital of East Orange, and Academy of Medicine)

19 **Chemical Control of Respiration**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

20 **Chest Case Conferences**
7:30 p.m.—Mountainside Hospital, Montclair
(Sponsored by New Jersey Thoracic Society and Academy of Medicine)

21 **Gastrointestinal Bleeding**
12 noon—Freehold Area Hospital, Freehold
(Sponsored by Academy of Medicine)

21 **Chemotherapy of Malignant Disease**
9 a.m.—St. Elizabeth Hospital, Elizabeth
(Sponsored by Academy of Medicine)

27 **Coronary Arteriography: Part II**
7:15-10:15 p.m.—Hospital Center at Orange
(Sponsored by Radiology Society of New Jersey and Academy of Medicine)

Mar.

1 8 15 22 **Orthopedic Surgery**
8:30 a.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

1 8 15 22 **Basic Science for Surgeons**
10 a.m.-12 noon—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

3 **Proper Use of Antibiotics**
8 p.m.—Community Hospital, Toms River
(Sponsored by Academy of Medicine)

3 **Proper Use of Antibiotics**
11:30 a.m.—Helene Fuld Hospital, Trenton
(Sponsored by Academy of Medicine)

3 **Distinguished Lectures in Surgery**
10 4-5 p.m.—Martland Hospital, Newark
17 *(Sponsored by CMDNJ, New Jersey Medical*
24 *School, and Academy of Medicine)*
31

5 **1974-75 Medical Lecture Series**
12 9-11 a.m.—Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and Academy of Medicine)

5 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 **Acupuncture**
2 p.m.—Christ Hospital, Jersey City
(Sponsored by Academy of Medicine)

5 **Advances in Medicine**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital and Academy of Medicine)

5 **Monthly Meeting**
8-10 p.m.—St. Joseph's Hospital and Medical Center, Paterson
(Sponsored by New Jersey Gastroenterological Society)

5 **Distinguished Lectures in Neuroscience**
12 10:30-11:30 a.m.—VA Hospital, East Orange
19 *(Sponsored by CMDNJ, New Jersey Medical*
26 *School, VA Hospital, East Orange, and Academy of Medicine)*

5 **Clinical Endocrinology**
12 3:30 p.m.—Martland Hospital, Newark Beth
19 Israel, and VA Hospital, East Orange (varies)
26 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

5 **Heart Block and Syncope**
12 **Renal Failure**
19 **Resuscitation in Shock and Trauma**
26 **Office Urology**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

5 **Clinical Interpretation of Diagnostic Laboratory**
12 **Tests**
19 3:30-5:30 p.m.—Rutgers Medical School, Pis-
26 cataway
(Sponsored by CMDNJ, Rutgers Medical School, and Academy of Medicine)

6 **Care of the Critically Ill Patient-Cardiac Arrests**
1 p.m.—Ancora Psychiatric Hospital, Hammonton
(Sponsored by Academy of Medicine)

6 **Clinical Nephrology**
13 4-5 p.m.—Martland Hospital Unit, Newark
20 *(Sponsored by CMDNJ, New Jersey Medical*
27 *School, and Academy of Medicine)*

8 **Anesthesiology Seminar**
9 Cherry Hill Inn, Cherry Hill
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

11 **Dermatologic Manifestations of Endocrine Tumors**
8 p.m.—White Laboratories, Schering Corporation
(Sponsored by New Jersey Dermatology Society and Academy of Medicine)

11 **Endotoxic Shock**
11 a.m.—Margaret Hague Maternity Hospital, Jersey City
(Sponsored by Academy of Medicine)

11 **Emergency Room Medical Care**
10:30 a.m.—North Hudson Hospital, Weehawken
(Sponsored by Academy of Medicine)

12 **Multiple Sclerosis, Demyelinating Diseases**
VA Hospital, East Orange
(Sponsored by Academy of Medicine)

12 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and the Academy of Medicine)

17 **Proper Use of Antibiotics**
8 p.m.—Irvington General Hospital, Irvington
(Sponsored by Academy of Medicine)

19 **Psychiatry; Family Therapy**
1 p.m.—Trenton Psychiatric Hospital, Trenton
(Sponsored by Academy of Medicine)

19 **Medical-Surgical Emergencies in Psychiatric Practice**
1:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(Sponsored by Academy of Medicine)

19 **The Rights of Childhood**
8-10 p.m.—81 Grand Avenue, Englewood
(New Jersey Medical Women's Association)

19 **Joint Monthly Sessions of Clinical Interest**
7-9 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)

19 **Cor Pulmonale**
11:30-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

20 **Renal Failure**
Somerset Hospital, Somerville
(Sponsored by Nephrology Society of New Jersey, New Jersey Regional Medical Program, Inc., Somerset Hospital, and Academy of Medicine)

20 **Chest Case Conferences**
7:30 p.m.—Overlook Hospital, Summit
(Sponsored by New Jersey Thoracic Society and Academy of Medicine)

21 **Renal Failure**
12:15 p.m.—Zurbrugg Memorial Hospital, Riverside
(Sponsored by Academy of Medicine)

21 **Fluid and Electrolyte Imbalance**
12 noon—Freehold Area Hospital, Freehold
(Sponsored by Academy of Medicine)

21 **Proper Use of Antibiotics**
9 a.m.—St. Elizabeth Hospital, Elizabeth
(Sponsored by Academy of Medicine)

25 **Mycologic Disease Syndromes**
11 a.m.—Perth Amboy General Hospital, Perth Amboy
(Sponsored by Academy of Medicine)

25 **Laboratory Interpretations**
8 p.m.—Warren Hospital, Phillipsburg
(Sponsored by Academy of Medicine)

27 **Sialography**
7:15-10:15 p.m.—Hospital Center at Orange
(Sponsored by Radiology Society of New Jersey and Academy of Medicine)

Apr.

2 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

2 **Common Errors in Practice**
9 **Medical Hypnosis**
16 **Functional Diseases**
23 **Interaction of Drugs Used in Cardiac Disease**
30 **Stroke Rehabilitation**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

2 **Clinical Endocrinology**
9 3:30 p.m.—Martland Hospital, Newark Beth
16 Israel, and VA Hospital, East Orange (varies)
23 *(Sponsored by CMDNJ, New Jersey Medical*
30 *School, and Academy of Medicine)*

2 **Clinical Interpretations of Diagnostic Laboratory Tests**
3:30-5:30 p.m.—Rutgers Medical School, Piscataway
(Sponsored by CMDNJ, Rutgers Medical School, and Academy of Medicine)

2 **Monthly Meeting**
8-10 p.m.—Newark Beth Israel Medical Center, Newark
(Sponsored by New Jersey Gastroenterological Society and Academy of Medicine)

2 **Proper Use of Blood Gases**
2 p.m.—Christ Hospital, Jersey City
(Sponsored by Academy of Medicine)

2 **Proper Use of Blood Gases**
2 p.m.—Cherry Hill Medical Center, Cherry Hill
(Sponsored by Academy of Medicine)

2 **Distinguished Lectures in Neuroscience**
9 10:30-11:30 a.m.—VA Hospital, East Orange
16 *(Sponsored by CMDNJ, New Jersey Medical*
23 *School, VA Hospital, East Orange, and Academy*
30 *of Medicine)*

3 **Proper Use of Antibiotics**
1:00 p.m.—Ancora Psychiatric Hospital, Hammonton
(Sponsored by Academy of Medicine)

3 **Clinical Nephrology**
10 4-5 p.m.—Martland Hospital Unit, Newark
17 *(Sponsored by CMDNJ, New Jersey Medical*
24 *School, and Academy of Medicine)*

5 **Orthopedic Surgery**
12 8:30 a.m.—Martland Hospital, Newark
19 *(Sponsored by CMDNJ, New Jersey Medical*
26 *School, and Academy of Medicine)*

5 **Basic Science for Surgeons**
12 10 a.m.-12 noon—Martland Hospital, Newark
19 *(Sponsored by CMDNJ, New Jersey Medical*
26 *School, and Academy of Medicine)*

7 **Distinguished Lectures in Surgery**
14 4-5 p.m.—Martland Hospital, Newark
21 *(Sponsored by CMDNJ, New Jersey Medical*
28 *School, and Academy of Medicine)*

8 **Office Surgery**
8 p.m.—White Laboratories, Schering Corporation
(Sponsored by New Jersey Dermatology Society and Academy of Medicine)

8 **Gastrointestinal Bleeding**
8 p.m.—Paul Kimball Hospital, Lakewood
(Sponsored by Academy of Medicine)

8 **Proper Use of Antibiotics**
10:30 a.m.—North Hudson Hospital, Weehawken
(Sponsored by Academy of Medicine)

9 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and the Academy of Medicine)

15 **Newer Concepts in Hepatitis Management**
12 noon—Hospital Center at Orange
(Sponsored by Academy of Medicine)

16 **Infertility**
11 a.m.—Margaret Hague Maternity Hospital, Jersey City
(Sponsored by Academy of Medicine)

16 **Hepatitis Management**
1:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(Sponsored by Academy of Medicine)

16 **Thanatology**
1 p.m.—Trenton Psychiatric Hospital, Trenton
(Sponsored by Academy of Medicine)

16 **Tuberculosis Before and After Chemotherapy**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

18 **Care of the Critically Ill Patient—Cardiac Arrests**
12 noon—Freehold Area Hospital, Freehold
(Sponsored by Academy of Medicine)

21 **Arteriography**
11:30 a.m.—Helene Fuld Hospital, Trenton
(Sponsored by Academy of Medicine)

22 **Hepatitis Management**
8 p.m.—Warren Hospital, Phillipsburg
(Sponsored by Academy of Medicine)

22 **Regional Chest Case Conferences**
7:30 p.m.—Christ Hospital, Jersey City
(Sponsored by New Jersey Thoracic Society and Academy of Medicine)

23 **Oral Manifestations of Systemic Disease**
9 a.m.-4 p.m.—VA Hospital, East Orange
(Sponsored by Academy of Medicine)

24 **Pancreatic Scanning**
7:15-10:15 p.m.—Hospital Center at Orange
(Sponsored by Radiology Society of New Jersey and Academy of Medicine)

25 **Medical Care in the Emergency Room**
12:15 p.m.—Zurbrugg Memorial Hospital, Riverside
(Sponsored by Academy of Medicine)

25 **Hepatitis Management**
9 a.m.—St. Elizabeth Hospital, Elizabeth
(Sponsored by Academy of Medicine)

May
1 8 15 22 29 **Clinical Nephrology**
4-5 p.m.—Martland Hospital Unit, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

3 10 17 24 **Orthopedic Surgery**
8:30 a.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

3 10 17 24 31 **Basic Science for Surgeons**
10 a.m.-12 noon—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 12 19 **Distinguished Lectures in Surgery**
4-5 p.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 **Clinical Endocrinology**
6 p.m.—Holiday Inn. East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 **Fluid and Electrolyte Imbalance**
2 p.m.—Christ Hospital, Jersey City
(Sponsored by Academy of Medicine)

7 14 21 28 **Distinguished Lectures in Neuroscience**
10:30-11:30 a.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, East Orange VA Hospital, and Academy of Medicine)

7 14 21 28 **Clinical Interpretation of Diagnostic Laboratory Tests**
3:30-530 p.m.—Rutgers Medical School, Piscataway
(Sponsored by CMDNJ, Rutgers Medical School, and Academy of Medicine)

7 14 21 28 **Clinical Endocrinology**
3:30 p.m.—Martland Hospital, Newark Beth Israel Medical Center, and VA Hospital, East Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 14 21 28 **Minor Surgery in Office Practice**
Learning Disabilities
Nutrition of the Aged
Emotional Aspects of Common Medical Problems
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital)

13 **Hepatitis Management**
8 p.m.—Paul Kimball Hospital, Lakewood
(Sponsored by Academy of Medicine)

13 **Fluid and Electrolyte Imbalance**
12 noon—Hospital Center at Orange
(Sponsored by Academy of Medicine)

13 **Proper Use of Laparoscopy**
11 a.m.—Margaret Hague Maternity Hospital, Jersey City
(Sponsored by Academy of Medicine)

13 **Proper Use of Blood Gases**
10:30 a.m.—North Hudson Hospital, Weehawken
(Sponsored by Academy of Medicine)

14 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and the Academy of Medicine)

14 **Respiratory Failure**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

19 **Proper Use of Blood Gases**
8 p.m.—Irvington General Hospital, Irvington
(Sponsored by Academy of Medicine)

21 **Joint Monthly Sessions of Clinical Interest**
7-9 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, East Orange VA Hospital, and Academy of Medicine)

22 **Regional Chest Case Conferences**
7:30 p.m.—The Medical Center at Princeton
(Sponsored by New Jersey Thoracic Society, and Academy of Medicine)

23 **Proper Use of Blood Gases**
9 a.m.—St. Elizabeth Hospital, Elizabeth
(Sponsored by Academy of Medicine)

27 **Psychiatry**
8 p.m.—Warren Hospital, Phillipsburg
(Sponsored by Academy of Medicine)

28 **Annual Awards Dinner**
6 p.m.—Chanticler, Millburn
(Sponsored by Academy of Medicine)

May 31-
June 3
Annual Meeting, MSNJ
Garden State Convention Center, Cherry Hill

June

4 **Clinical Endocrinology**
3:30 p.m.—Martland Hospital, Newark Beth Israel Medical Center, and VA Hospital, East Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 **Thanatology**
1 p.m.—Ancora Psychiatric Hospital, Trenton
(Sponsored by Academy of Medicine)

7 **Orthopedic Surgery**
8:30 a.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7, 14, 21, 28 **Basic Science for Surgeons**
10 a.m.-12 noon—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

10 **Difficult Diabetic Patient**
8 p.m.—Paul Kimball Hospital, Lakewood
(Sponsored by Academy of Medicine)

11 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and the Academy of Medicine)

18 **Joint Monthly Sessions of Clinical Interest**
7-9 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, East Orange VA Hospital, and Academy of Medicine)

24 **Hepatitis, Acute and Chronic**
11 a.m.—Perth Amboy General Hospital, Perth Amboy
(Sponsored by Academy of Medicine)

24 **Thyroid Diseases**
8 p.m.—Warren Hospital, Phillipsburg
(Sponsored by Academy of Medicine)

27 **Endotoxic Shock**
9 a.m.—St. Elizabeth Hospital, Elizabeth
(Sponsored by Academy of Medicine)

OBITUARIES

Dr. Murray Abrams

Murray Abrams, M.D., a member of our Monmouth County Medical Society, died suddenly in Atlantic City on September 28, 1974. Born in New York in 1912 and graduated from New York University School of Medicine in 1936, Dr. Abrams was director of the department of otolaryngology at Monmouth Medical Center in Long Branch. Following service with the AUS during World War II, he was associated with New York Post Graduate Medical School and New York Polyclinic Medical School before coming to Monmouth County in 1954. He was board certified in his chosen field and was a member of the American Association of Ophthalmology and Otolaryngology and the Society for Advancement of Reconstructive Plastic Surgery.

Dr. Isaac Battin, Jr., M.D.

Isaac Battin, Jr., M.D., Associate Director of Psychiatry at the Hunterdon Medical Center in Flemington, died on September 12, 1974, at the hospital. Born in Raleigh, North Carolina, Dr. Battin received his doctor of medicine degree from the Medical College of Boston University in 1963 and took his residency in psychiatry at that same institution. Upon completion and certification by the American Board of Psychiatry and Neurology, Dr. Battin pursued a teaching career at his alma mater until 1972 when he accepted a position as assistant director of the inpatient psychiatric unit of the Springfield (Mass.) Hospital Medical Center. He came to the Hunterdon Medical Center just a year ago. He was a member of the American Psychiatric Association and was Assistant Clinical Professor of Psychiatry at CMDNJ. Dr. Battin was 44 years old at the time of his death.

Dr. Leslie S. Denbo

At the untimely age of 38, Leslie S. Denbo, M.D., died tragically on August 13, 1974, as the result of an automobile accident. A transfer to Ocean from the Camden County Medical Society in 1973, Dr. Denbo practiced general medicine in Brant Beach. He had formerly had offices in Collingswood and had been associated in the surgery and proctology departments at Cooper Hospital in Camden, Kennedy Hospital in Stratford, Zurbrugg Hospital in Riverside, and Jefferson Medical Center in Philadelphia. He was a 1961 graduate of SUNY, Downstate, and had done graduate work in Ireland.

Dr. Joseph DiNorcia

On September 21, 1974, Joseph DiNorcia, M.D., a member of our Essex County component, died at Clara Maass Memorial Hospital where he had long been a member of the attending staff. Born in 1910, Dr. DiNorcia was a 1935 graduate of the Medical College of Syracuse University and had practiced internal medicine in Newark, Glen Ridge, and Belleville all of his professional career. In addition to his association at Clara Maass, he was on the staff at Columbus Hospital in Newark. Dr. DiNorcia was a Fellow of the American College of Cardiology and a member of the American Heart Association. He served as a medical officer in the AUS during World War II.

Dr. Irving W. Friend

Word has just been received of the death on August 5, 1974, of Irving W. Friend, M.D., a general practitioner from Kearny. Born in 1928 and a graduate of SUNY, Downstate, class of 1954, Dr. Friend had been a well-known family physician in Essex County since his return from active duty with the medical department of the U.S. Navy in 1957. He was on the staff at West Hudson Hospital in Kearny and Clara Maass Hospital in Belleville and was a diplomate of the American Board of Family Practice and a member of the American Academy of Family Practice.

Dr. Herbert L. Goodman

Herbert L. Goodman, M.D., a member of the Essex County Medical Society, died on July 31, 1974. Born in Allentown, Pennsylvania, in 1924, Dr. Goodman received his M.D. degree from Albany Medical College in 1949, and, following graduate work in pathology and hematology and duty in the medical department of the US. Army, he came to New Jersey to accept appointment at the Laboratory of the East Orange General Hospital, of which he was the Director at the time of his death. He was a diplomate of the American Board of Pathology, both anatomical and clinical, was a Fellow of the American College of Pathologists, and a member of the American Association of Blood Banks, the American Society of Clinical Pathologists, and the Academy of Medicine. He was active in community affairs and had been medical director of the Essex County Blood Bank and director of cytology at the East Orange Department of Health.

Dr. Joseph A. Pinto

On August 12, 1974, Joseph A. Pinto, M.D. of West Orange, died suddenly at his home. Born in 1911, Dr. Pinto was a graduate of the Medical College of George Washington University, class of 1937 and had been a general practitioner in the Newark area for many years. He was associated with Presbyterian Hospital in Newark. Dr. Pinto had served for three years as a medical officer in the AUS during World War II.

Dr. Philip R. Stewart

Philip R. Stewart, M.D., a member of our Essex County Medical Society, died on September 4, 1974, at the untimely age of 48. Born in Texas and educated in France, Dr. Stewart received his M.D. from the University of Paris in 1956. After residencies in internal medicine in Chicago, he came to New Jersey in 1968 and established a practice in Newark. He was associated with Orange Memorial, Clara Maass, Beth Israel, Crippled Children's, and Presbyterian Hospitals.

BOOK REVIEWS

Review of Medical Microbiology, 11th Ed. Ernest Jawetz, J. L. Melnick, and E. A. Adelberg. Los Altos, California, Lange, 1974. Pp. 528. Illustrated (Softback—$8.50)

This book, now in its twentieth year after 11 biennially revised editions, has nurtured the minds of twenty "generations" of medical students. It has been translated into seven foreign languages, suggesting that it is as popular in other parts of the world as it is in the United States.

This latest edition has maintained the high standards of up-to-date coverage that characterized the earlier ones. The development of new knowledge in the various subdisciplines of microbiology has been so rapid that frequent revision has become essential. This is particularly true for chemotherapy, immunology, and virology. Advances in our understanding of macromolecular interactions in cells of all kinds, of cellular membrane structure, function, and interrelationships, and of genetics have had a profound and continuing impact on the study and management of infectious, immunological and genetic disorders in man. It is fortunate that this *Review of Medical Microbiology*, like similar Lange publications in other fields, has retained a format (soft cover, presentation of each specialty in many easily revised chapters and subsections, relatively low cost geared to mass production and mass sale) that facilitates insertion of new information. About one-half of the references at the end of each chapter are to publications that have appeared in the last two or three years!

In this edition, the three senior authors are joined by M. Benyesh-Melnick (Oncogenic Viruses) and the late J. Ralph Audy and two of his colleagues (Parasitology). All authors are distinguished experts in their fields. The book has weaknesses: stylistic elegance is sacrificed to brevity and clarity, and this makes for uninspiring reading; some erroneous bits of information have been carried over from earlier editions. On the whole, however, the book is excellent for its purpose and should be in every medical (and other health-related) student's and professional's personal library as a convenient source of learning and on-the-spot information.

R. Walter Schlesinger, M.D.

Awakenings. Oliver W. Sacks, M.D. New York, Doubleday, 1974 Pp. 249 ($7.95)

This is a heady treatise on persons with Parkinsonism written somewhat in the style of Thornton Wilder's *Bridge of San Luis Rey*. The characters are Parkinsonian inmates of an institution originally called "The Mount Carmel Home for the Crippled and Dying." The author details the personality backgrounds in some depth. Most have been long institutionalized post-encephalitic Parkinsonians. He treats them and the thesis with an existential approach. His interest is intrigued with the abundance of ticcing elicited so often, as the euphoria of the "awakening" reaction with L-dopa overwhelms each one's ego resources and "splits of behavior ensue," "molar" splitting (hysterical dissociation) to "molecular" splitting (schizophrenic dissociation). The book plays down L-dopa and analogizes the initial enthusiasm to the drug to Freud's promotion of cocaine. In light of the reviewer's experience as monitor for an early research team and later experiences with ambulatory patients, he could not help but wonder whether the world in which these patients lived and the author's own deep interests may not have led to quite so much emotional chaos. The author has an amazing familiarity with poetry and philosophy. The book serves as a cogent reminder of the close relationship between neurology and psychiatry and the regrettable widening of the split between these disciplines.

Ira S. Ross, M.D.

The Doctor and the Athlete, 2nd Edition. Isao Hirata, Jr., M.D. Lippincott, Philadelphia, 1974. Pg. 272, plus appendix and index. ($16)

A second, expanded edition of a reasonably specialized volume on athletic medicine indicates the well-deserved success of the original work and also the rapid changes and advances in this field. In recent years, *The Journal,* MSNJ, has published several original articles that have recognized the special medical knowledge and skills required to provide quality medical care to the millions of people, our patients, who participate in sports. This volume by an experienced, scientific, understanding surgeon, dedicated to care of the patient, brings together a vast amount of information.

Not an exhaustive encyclopedia, yet it covers everything from "shin splints," the "hip pointer," artificial turf, and fundamentals of taping, to the philosophy of medical care in this specialized but vital area. Any physician from the casual "fill-in" team physician at a little league game to the most ardent, regular and experienced "pro" physician should benefit from this near classic. It is strongly recommended for those trainers and coaches who lack the necessary medical support and suggested also for school board members, little league trustees, and all others who are conscientious about safe, healthful athletic programs.

James E. D. Gardam, M.D.

Handbook of Psychiatry. P. Solomon and V. D. Patch, Editors. Los Altos, California, Lange, 1974. Pp. 706. (Softback—$8)

Most physicians are wary of handbooks—they are neither fish nor fowl. It's almost always safer to use a textbook, or to review the journal literature. But here is a great handbook that is broad in its scope, and covers the varied viewpoints in this very discordant field of psychiatry.

The book is written in a concise, somewhat terse, but readable fashion, and is well organized. It not only includes sections encompassing psychiatric illnesses and psychiatric treatment of all kinds, but there is an initial section devoted to psychiatric background. The latter includes the areas of genetics, epidemiology, mental hospitals, and statistics, among others.

There are special chapters on college psychiatry, forensic psychiatry, and transcultural psychiatry that are excellent. The final chapters in the book spell out a psychiatry emergency routine for the physician to follow in a "cookbook" fashion—a routine that is brief but quite practical.

This is a good book for the non-psychiatric physician (or student) to have at his fingertips, since it is intended for reading consultation when psychiatric problems arise. It won't gather dust.

Seymour F. Kuvin, M.D.

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the JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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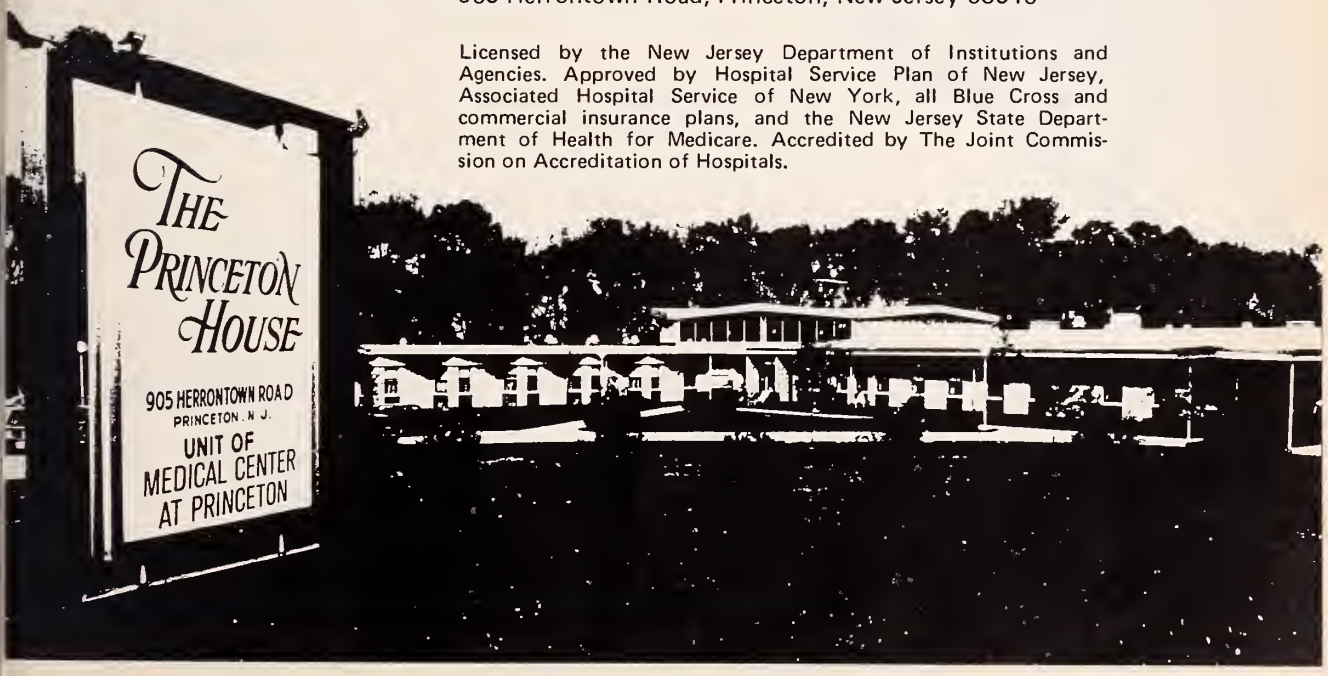

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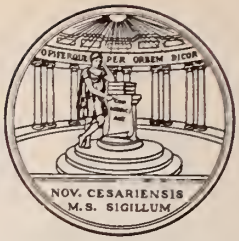

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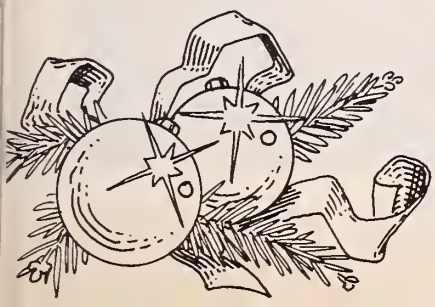

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EDITORIALS

Louis Keeler Collins, M.D. 1911-1974

Louis Keeler Collins, M.D., 175th President of The Medical Society of New Jersey, died on October 28, after a protracted illness. By his death the Society was deprived of one of its most distinguished Fellows, and the medical profession of New Jersey lost one of its most dynamic and popular leaders.

Doctor Collins obtained his bachelor of science degree in 1931 from Pennsylvania State University; he received his M.D. degree from Jefferson Medical College in 1934. In World War II, he served for three and one-half years as a flight surgeon with an air-evacuation squadron in the China-Burma-India theater. He was awarded the Air Medal, Distinguished Flying Cross, and the Purple Heart.

A lineal descendent of the first practicing physician in Gloucester County, Doctor Collins established his practice in Glassboro in 1937 and maintained it there through the years. From the time of his entry into practice, Doctor Collins actively identified himself with organized medicine. He served the Gloucester County Medical Society in many capacities, including its presidency. Elected by his County Society as one of its representatives in the House of Delegates of The Medical Society of New Jersey, he served with distinction in the House for more than a score of years and then advanced to membership on the Board of Trustees and ultimately to the presidency in 1967. Following his presidency, Doctor Collins served for many years as a member and chairman of MSNJ's Council on Medical Services.

Constantly and consistently he devoted himself to the welfare of patients and the freedom of Medicine. In his address as retiring President, Doctor Collins summarized his credo in the following words:

> "The freedom I prize most highly is my freedom to practice medicine as I see fit. I believe that I should have the right to practice solo, in a group, as an individual physician, as a college doctor, as a full-time man in a hospital, or in any other way I choose, so long as I practice good medicine in the best interest of the people I treat and serve."

Strong in his convictions and earnest and forthright in his support and defense of his principles and ideals, Doctor Collins was, nevertheless, a sparkling friendly and genial spirit. He stimulated and buoyantly encouraged all with whom he came in contact. He met life—and death—with an inner strength and balance that were as rare as they are edifying. "He was a man, take him for all and all . . ." We shall not soon see his like again.

R.I.N.

Blood Banking in New Jersey

The North Jersey-Essex County Blood Bank, a non-profit organization, which is a member of the American Association of Blood Banks, has called to our attention efforts by the Greater New York Blood Program to expand its activities into our State and to seek funds from New Jersey for its purposes. They pointed out that the New York group has fostered the concept that they should handle blood-banking for the "nine northernmost counties of New Jersey, along with New York City and the fourteen southernmost counties of New York State."

Analysis of the data from 1967 to 1974 shows that only two-thirds of all blood collected in our State by the Greater New York and Philadelphia Blood Programs was returned for the benefit of our citizens. Furthermore, New York charged a 20 percent higher processing fee per blood unit.

The American Medical Association, the American Association of Blood Banks, the American National Red Cross, and the Council of Community Blood Centers are playing a guiding role in the establishment of "an

American Blood Commission that would assure a national all-volunteer supply of blood for transfusions and medical emergencies." Their proposed plan is for a "volunteer program controlled at the local level, with medical societies playing a major role."

New Jersey's blood banks in Essex, Passaic, Bergen, and Monmouth Counties appear to be meeting the blood needs of their respective regions. In the best interest of our citizens, it seems quite clear that New Jersey's blood needs should be met by New Jersey facilities, with participation of The Medical Society of New Jersey and its county components and the New Jersey State Department of Health. There should be no intervention or control by an out-of-state agency such as the New York group. A.K.

Music and Medicine

At a recent concert by the Cleveland Symphony Orchestra, under the direction of Lorin Maazel at Princeton's McCarter Theatre, a medical event, which was not on the printed program, took place. The orchestra was midway through the first movement of a Mozart symphony when an elderly gentleman in the third row had a cardiac arrest. Within a few seconds, a pediatrician from the second row was administering cardio-pulmonary resuscitation, while the maestro continued to conduct. In another minute or so, an additional four physicians from the audience were assisting.

Physicians seem to have a special love for music (and the arts) and can be found in abundance at almost every serious musical event. The call, "Is there a doctor in the house?" rarely goes unanswered. Besides the passive role as listener, however, many doctors have studied and performed, and still actively perform in our State. One of our colleagues, Dr. Conrad de Filippis, a South Orange surgeon, is an internationally recognized composer of three hundred musical works, some of which have been performed at the San Remo Festival in Italy and at Newark's Symphony Hall.

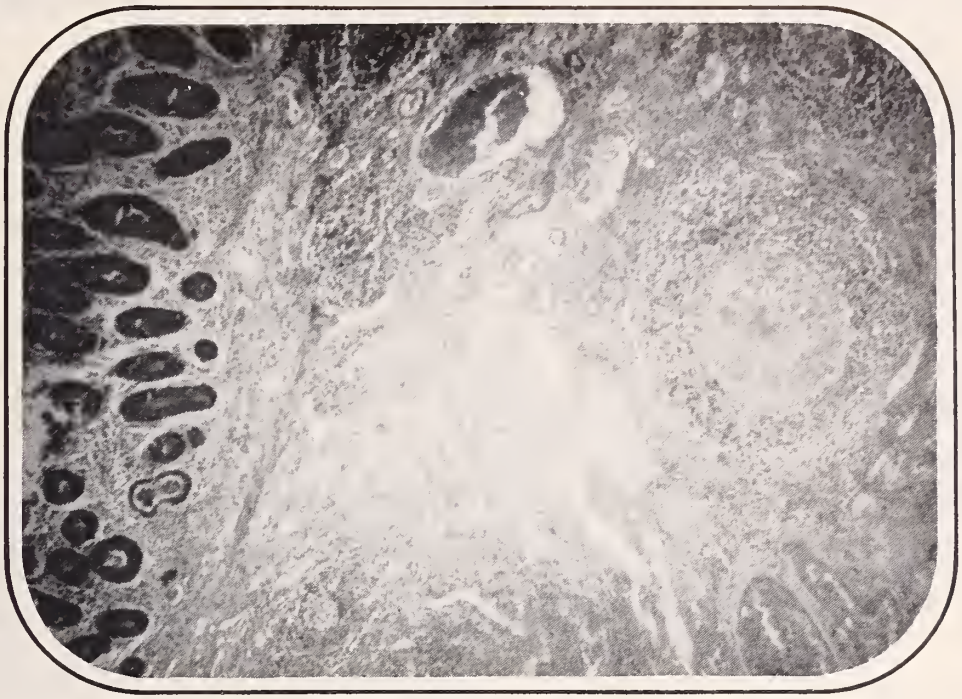
The late Virginia Apgar of Tenafly was widely known, nationally and internationally, for "The Apgar Score," a method of evaluating newborn infants. Less well known were Doctor Apgar's musical accomplishments. A violist, she had performed with symphony orchestras and was a member of amateur chamber music groups. She was also a member of the Catgut Acoustical Society, a group that made its own string instruments.

Any number of New Jersey physicians and their children have had the good fortune of summer training at the famous National Music Camp at Interlochen, Michigan. Although the amateur performers among our medical profession might have planned a musical career and changed to medicine for personal reasons, some helped "work their way" through medical school by exploitation of their talents with dance bands or other musical events on weekends. The late Louis Wolff, Clinical Professor of Medicine at Harvard Medical School and codescriber of the Wolff-Parkinson-White Syndrome, did just that—with his violin!

Although chamber music seems to be more attractive to physicians, for obvious reasons of time and logistics, there are a number of full symphony orchestras whose members are in the health professions. The Los Angeles Doctors' Symphony Orchestra, for example, celebrated its twentieth anniversary in 1974, while the Brooklyn Doctors' Symphony Orchestra has been active for more than three decades; there are also similar orchestras in St. Louis, Missouri and Akron, Ohio.

Physicians doubtlessly perform in trios, quartets, and other groups throughout our State for their own satisfaction and for the entertainment of others. If The Medical Society of New Jersey has enough musically trained members to form a full concert orchestra or a smaller ensemble, the annual meeting might be just the spot for such a group to perform. How about it? A.K.

ctive
granulomatous
r ulcerative
olitis?*



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ORIGINAL ARTICLES

Fiberoptic bronchoscopy has recently been added to our methods in diagnosis and therapy of lung disease. The experience in a 500-bed community hospital is presented and discussed.

Flexible Fiberoptic Bronchoscopy*

Experience in a Community Hospital

David Segall, M.B., B.S.†/Long Branch

The flexible fiberoptic bronchoscope which was recently introduced to many pulmonary medicine services in the United States was popularized after the initial papers by Ikeda of the National Cancer Center Hospital in Tokyo in 1968[1,2]. The author reported 360 cases in which both rigid and flexible bronchoscopy examinations were done; only 159 (44%) tumors were visualized with the rigid instrument, while 140 additional cases (39%) were visualized with the flexible fiberoptic instrument. More recently, fiberoptic bronchoscopy has been used in the management of acute respiratory failure, particularly for the treatment of atelectasis.[3,4]

The present report outlines the experience in a 500-bed community hospital during a one-year period.

Methods

Diagnostic bronchoscopy — All procedures were carried out in a minor surgery room. The bronchoscope was passed by the nasal route without prior intubation or rigid bronchoscopy. An intravenous line, supplementary nasal oxygen, and electrocardiogram monitoring were employed. The patient was premedicated with meperidine and atropine and the airway anesthetized with 1% lidocaine, particular attention being paid to anesthetize adequately each new landmark. It is emphasized that the operating room and general anesthesia were not used.

Therapeutic bronchoscopy — Bronchoscopy during episodes of acute respiratory failure was carried out by way of a pre-existing endotracheal or tracheostomy tube. Mechanical ventilation was continued during the procedure by way of a volume-cycled ventilator connected through the side arm of a "T" tube adaptor. An air seal was obtained by using an endotracheal tube cuff balloon.

Results

There were 73 procedures carried out in 57 patients (Table I); 24 procedures were performed on 8 patients, primarily for recurrent atelectasis during mechanical ventilation (Table 2). In all cases, at least partial reexpansion was obtained (Figure 1); however, it was found necessary to maintain an artificial airway for airway toilet in order to prevent recurrence. Additional diagnostic indications for bronchoscopy are shown in Table 3. Carcinoma of the lung was relatively un-

Table 1

Analysis of Fiberoptic Bronchoscopy in a 12-Month Period in a 500-Bed Community Hospital

Indications	*Number of Patients*
(a) Atelectasis associated with mechanical ventilation	25
(b) Diagnostic	32

Table 2

Indications for Multiple Bronchoscopies (24)

Indications	*Number of Patients*
(a) Recurrent atelectasis	5
Primary diagnosis Guillain Barre	
1—expired	
Post-op atelectasis	
4—1 expired	
(b) Carcinoma of the lung for more adequate biopsy	2
(c) Bronchial stenosis due to sarcoidosis Follow-up observation	1

*Read before the Joint Session of the Sections on Anesthesiology, Ophthalmology, and Otolaryngology, 208th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 12, 1974. Dr. Segall is Director of Pulmonary Medicine, Monmouth Medical Center, Long Branch, New Jersey.

†Bachelor of Medicine, Bachelor of Surgery

common since these patients are often referred directly to a thoracic surgeon.

Table 3
Diagnostic Indications

Diagnosis	*Number of Patients*
Carcinoma of the lung	11
Bronchiectasis	4
Chronic obstructive lung disease	3
Hodgkin's disease with pulmonary infiltrate	3
Hemoptysis of unknown cause	2
Sarcoidosis	2
Atypical mycobacteria	1
(with lung abscess)	1
Hernia of Bochdalek	1
Histoplasmosis	1
Non-specific lung abscess	1
Sequestration	1
Tracheal stenosis	1
Total cases	32

On several occasions, arterial blood gases were measured during bronchoscopy when mechanical ventilation with an inspired oxygen concentration (FIO_2) of 100 percent was used. Satisfactory levels for arterial partial pressures of carbon dioxide and oxygen (pCO_2, pO_2 respectively) were observed.

Complications

One patient, with atelectasis of the left lung on mechanical ventilation, developed a pneumothorax on the contra-lateral side shortly after the procedure. This may have been caused by excessive coughing. A patient undergoing lung biopsy with the fiberoptic bronchoscope complained of pleuritic pain at the time of the biopsy bite; a 60 percent pneumothorax was discovered and required chest drainage. A diagnosis of pulmonary sarcoidosis was made. Other reported complications of fiberoptic bronchoscopy, in addition to the pneumothorax, include fever (17 percent of cases) and pulmonary infiltrates (7 percent).[9]

The illustrations here exhibited reveal various procedures carried out with the fiberoptic bronchoscopy.

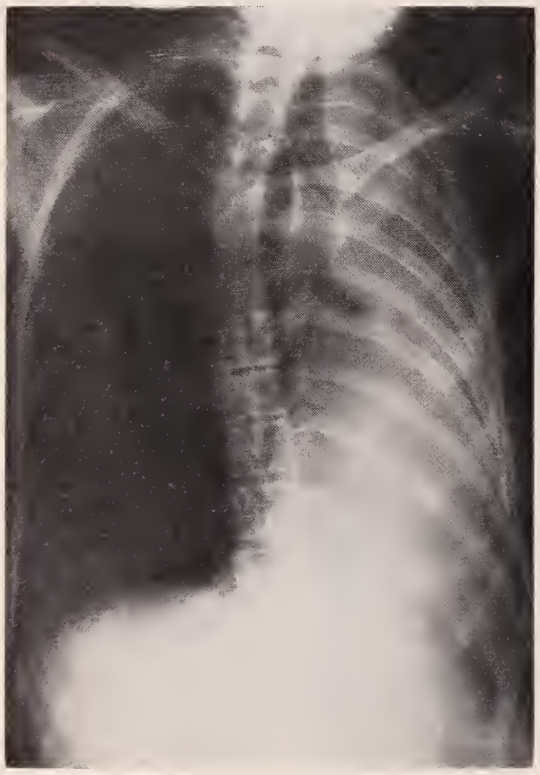

Figure 1—Demonstrates total atelectasis of the left lung. This is characterized by a homogeneous density of the left hemithorax and a shift of the mediastinum to that side. This occurred in a 55 year old white female following surgery to the cervical spine for a spinal cord tumor. Following surgery she was unable to cough and developed atelectasis.

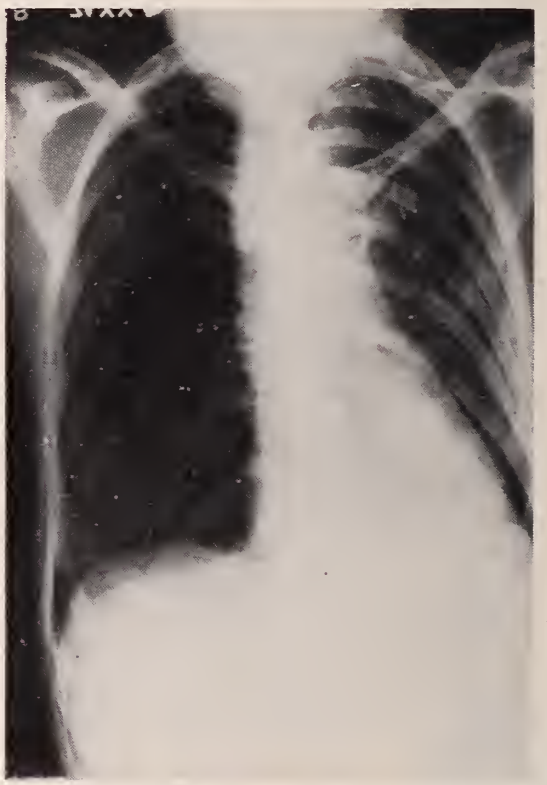

Figure 2—Demonstrates re-expansion of the left lung following fiberoptic bronchoscopy. A tracheostomy was also done in this patient in order to permit adequate airway toilet in order to prevent a recurrence of atelectasis.

Figure 3—Demonstrates the marked flexibility of the fiberoptic bronchoscope and shows the bronchial brush in the apex of the left upper lobe.

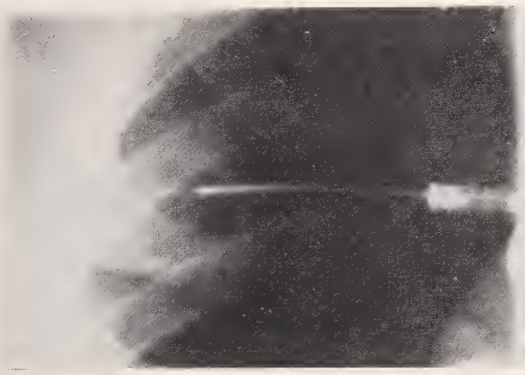

Figure 4—Demonstrates the bronchial brush in a peripheral lung abscess. This was confirmed by both posterior-anterior and lateral fluoroscopy. Diagnosis on this patient was nonspecific lung abscess. Bronchial brushing revealed inflammatory cells only. It should be pointed out, however, that finding of inflammatory cells is nonspecific and does not rule out carcinoma.

Figure 5—Demonstrates a mass lesion within the mainstem bronchus typical of a bronchogenic carcinoma. This was found in an elderly male with a history of hemoptysis and heavy cigarette smoking. Diagnosis was confirmed by histology.

This slide demonstrates the use of the bronchoscope as a teaching tool since this illustration was found to be very effective in our Stop Smoking Clinic.

Discussion

The fiberoptic bronchoscope was found to be an invaluable adjunct to our pulmonary service. This was particularly true in the management of atelectasis during the course of respiratory failure, involving mechanical ventilation, where rigid bronchoscopy would be hazardous. The flexible instrument was readily passed through the pre-existing nasotracheal, orotracheal, or tracheostomy tube without difficulty. Selective suctioning and appropriate biopsies were taken without difficulty. It should be emphasized that adequate ventilation and oxygenation can be readily maintained without difficulty using a volume-cycled ventilator and appropriate side arm adaptor.

For diagnostic bronchoscopy, the use of the fiberoptic instrument has made the procedure much less formidable for the patient; it appears to be relatively free from hazard, so that the indications for its use can be widened. With this instrument a far more complete examination of the airways, including segmental, subsegmental and more distal bronchi, can be carried out, greatly increasing the diagnostic yield[1].

A method of transbronchial lung biopsy using the rigid bronchoscope was used in 335 patients with a success rate of 82 percent[5]. No mortality was reported, but pneumothorax of minor extent developed in 48 cases. This technique has now been adapted for the fiberoptic instrument.[6] By this method, the present author was able to make a diagnosis of pneumoconiosis due to talc in a young woman who was suspected of miliary tuberculosis. Transbronchial biopsy has also been described using a guide wire and fluoroscopy instead of flexible bronchoscope.[7]

A transient reduction in pulmonary function including significant fall in pO_2 after fiberoptic bronchoscopy, particularly in patients with chronic obstructive lung disease has been demonstrated.[8] Supplementary oxygen and assisted ventilation may thus be required when initial function is poor.

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Treatment and Rehabilitation of Drug Addicts

The Lexington, Kentucky, hospital for the treatment and rehabilitation of drug addicts was transferred from Public Health Service auspices to the Department of Justice where the Bureau of Prisons will use it to treat narcotic addicts who have been convicted of crimes.

Dr. Charles C. Edwards, Assistant Secretary of Health, said the turnover of the Lexington treatment facility has been made possible by the network of treatment programs developed across the nation with Federal assistance. "These programs," he said, "permit addicts to receive care close to or in their own hometowns, which narcotics authorities feel is a much more efficient method than institutionalization."

Approximately 100,000 admissions have been made to Lexington during its lifetime, more than half of them "repeaters." Congress originally authorized establishment of two "narcotic farms"—the second was at Fort Worth, Texas—in 1929 with the goal of treating and studying addiction and isolating addicts from other Federal prisoners. Lexington opened in 1935 and Fort Worth in 1938. The latter was discontinued as a Public Health Service Hospital in 1971, as the number of community-based programs began to expand rapidly.

Although the first Lexington admissions were prisoners, volunteer patients—addicts eager to obtain the only treatment then available in the U.S.—soon accounted for more than 75 per cent of the total. Some believed they would be cured simply by withdrawal; others only wanted to reduce costly heroin habits, not give up the drug altogether. More than two-thirds left "against medical advice." For many, the hospital became a "revolving door" through which they passed repeatedly.

In 1966, the Narcotic Addict Rehabilitation Act was enacted to overcome this futile process. It had become apparent that supportive rehabilitation after release from inpatient care was a critical factor in preventing a return to drug use. The administration of Lexington was transferred to the National Institute of Mental Health. Under the new law, up to six months of inpatient treatment is provided to addicts committed by a Federal Court, followed by three years of supervised aftercare in the addict's own community. Patients may be committed in lieu of prosecution for certain Federal offenses, or they may seek commitment voluntarily. They may not withdraw from the program voluntarily. Since 1967, Lexington has treated more than 7,000 of the 11,000 NARA patients to date, from every state but Maine and North Dakota.

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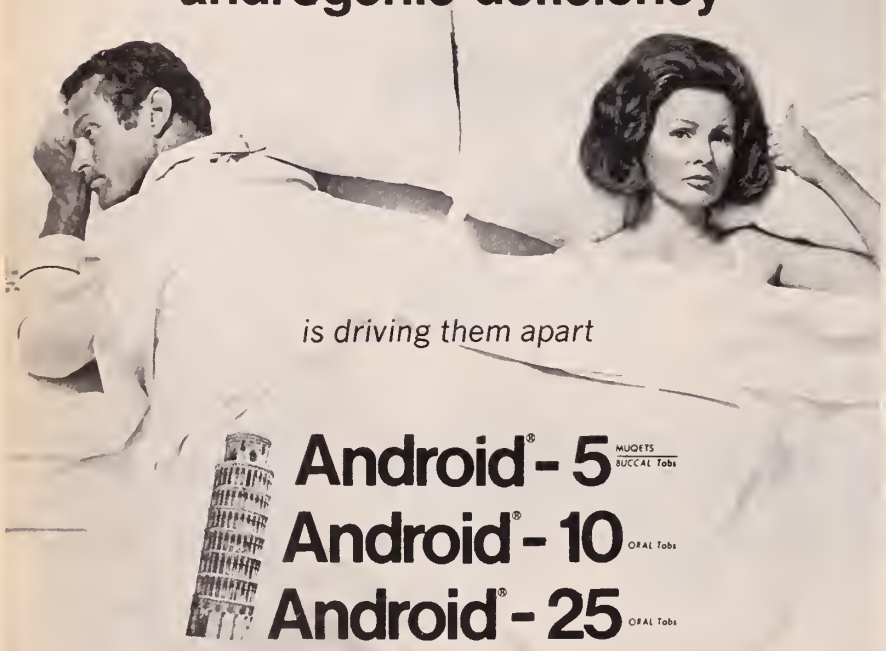

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A Pediatric Intensive Care Unit (PICU) was established at Children's Hospital of Newark and during its first year of operation admitted 193 patients between the ages of two months and 15 years, with a mortality of 8 percent. It seemed that an improvement in quality of care, an increase in efficiency, and a reduction in costs occurred and the unit became a regional resource. Development of a PICU should be considered if there is a demonstrable need and if adequate supportive and supervisory personnel are available.

The Pediatric Intensive Care Unit*

Richard H. Rapkin, M.D./Green Brook

There has been general agreement in the medical community that segregation of patients into groups for special and/or intensive care is desirable. The modern physician is uncomfortable without a coronary care unit or an intensive care unit in his hospital. He is familiar with the existence, in all hospitals, of a special unit for postoperative care: the recovery room. Special groupings such as burn units, trauma units, metabolic units, and dialysis units are well known but are usually confined to larger or more sophisticated (tertiary) hospitals.

More recently, the neonatal intensive care unit has come into being and has demonstrated its value, both in reduction of mortality and in improvement in the quality of life of its survivors. Regionalization of such units has become recognized as desirable, in order to improve efficiency and quality of care.

In the past few years still another type of patient care area has been proposed and has not been widely accepted as yet: the pediatric intensive care unit. This area is conceived as able to provide special care for older infants and children. It has been suggested that these children are not ideally cared for in an adult intensive care unit nor in a neonatal intensive care unit. Additionally, the development of these units on a regional basis has been recommended.

In the Spring of 1973, Children's Hospital of Newark established a Pediatric Intensive Care Unit (PICU). This report is based on the first year's experience with the Unit.

Materials and Methods

A four-bed PICU was established. Appropriate monitoring equipment, electrical capacity (approximately 40 amps/bed) and lighting was arranged. A working area per bed of 120 square feet and a total of 600 square feet was provided. The Unit was organized as a separate nursing area, with its own head nurse; it was staffed with specially trained nurses in a ratio of approximately 1 nurse per bed each shift (1:1). A blood gas laboratory (run by inhalation therapy) was established immediately adjacent to the PICU.

Although no physician was assigned to the Unit full time, the care was provided jointly by the pediatric and pediatric surgical house staff under the supervision of full-time pediatric, pediatric surgical, pediatric cardiac, and anesthesiology attending staff. No specific director was appointed. Most patients were managed cooperatively since the majority had both medical and surgical needs.

Results

In the first full year of operation, the Unit admitted 193 patients between the ages of 2 months and 15 years—98 patients were predominantly medical problems and 95 surgical (Table 1). There were 16 deaths (8.3 percent). The average length of stay, excluding 7 "boarders" who remained more than 28 days and up to 6 months, was 4.5 days. Eighty-five patients were in the Unit for 2 days or less. The average census was 3. There were 78

* This work is from the Children's Hospital of Newark, where Dr. Rapkin is Director of Pediatrics, and the Department of Pediatrics of the New Jersey Medical School, CMDNJ.

patients (40 percent from outside of Essex County).

Table 1

Admissions to PICU from April 1973 through March 1974

Diagnosis	*Care Predominately:* Medical	Surgical	Deaths
Croup and Epiglottitis	14		0
Bronchiolitis, Asthma and Pneumonia	9		0
Meningitis and Encephalitis	5		3
Convulsions	6		0
Bleeding Diatheses	4		0
Poisonings	5		0
Gastroenteritis	7		0
Malabsorption	4		0
Miscellaneous*	9		0
Heart Disease	35	16	7
ENT Surgery		10	0
Tracheal Surgery		10	2
Chest Surgery		3	0
GI Surgery		22	0
GU Surgery		9	1
CNS Surgery		17	2
Miscellaneous Surgery**		8	1
TOTAL	98	95	16

*Miscellaneous: Renal 2, Burn 2, Hypoglycemia 1, Collagen 1, Bronchiectasis 1, Sepsis 1, Rocky Mt. Spotted Fever 1.

**Miscellaneous Surgery: Multiple Injuries 5, Multiple Anomalies 3.

The diagnoses (Table 1) do not necessarily indicate the reason for being in the PICU. A significant number of patients were in the Unit for special procedures (e.g., intravenous alimentation) or respiratory care (e.g., tracheostomy or endotracheal intubation). Transfer to and from the PICU from the pediatric floor was not unusual.

Superficial cost analysis of care in the PICU indicated an approximate doubling of usual hospital per diem costs. The majority of the cost appeared to be due to the greatly increased nurse to patient ratio.

Discussion

The justification for a PICU will basically be found in the answer to the questions: What services are provided in the PICU that are not otherwise available? Will quality of care (decreased mortality and morbidity) be enhanced? Is the improvement of care, if any, worth the expense? Is there sufficient need for such services? What substitutes are available? Definite answers to these questions are not yet known, but our experience in the past year justifies an attempt to answer, although the conclusions are speculative.

Our reason for establishing the PICU was that the services of intensive nursing care were regularly needed on our pediatric floor and it was necessary to make an *ad hoc* unit out of a regular patient room; the electrical supply was often insufficient, the area too small, and the nurses inadequately trained. The substitute of a distinct service area with a small cadre of well trained and constantly refreshed nurses, with adequate facilities, could not help but improve services. It seems obvious that any hospital finding a need for 1:1 nursing of pediatric patients occurring regularly (at least daily) should consider establishing a PICU.

The enhancement of care quality appeared to be improved, but careful assessment depends upon prospective studies. It is obvious to all that intensive nursing care is necessary for certain patient problems, but whether establishing a specific unit enhances quality is not known. Because of the great variety of patients seen during the year studied, no comparison of similar patients handled in our *ad hoc* way could be made.

The expense of a PICU is related directly to its regularity of use. Since patients involved received similar care prior to the development of the Unit, the differences in cost would depend upon whether the PICU is well filled. We found that some patients, who would have to be nursed in a 1:1 fashion in separate rooms, could be segregated together in the PICU and be satisfactorily cared for at a nursing to patient ratio of 1.2. Efficiency seemed enhanced thereby.

The need for services may parallel Parkinson's law: the demand expands to fill the services available. We did not allow patients to remain in the Unit who did not require its special care. Utilization increased, however, as our own physicians and then other referring physicians became aware of the service and

sought to have their patients cared for. The regional nature of the PICU became obvious in our retrospective review: 40 percent of patients were referred from outside Essex County.

The question of whether the neonatal or adult intensive care units are reasonable substitutes is not clearly answered. We have found that small infants with cardiorespiratory problems are best handled by the neonatal intensive care unit and its cadre of staff geared to dealing with feeding, temperature regulation, and small volume fluid and electrolyte problems. Certainly the adult intensive care unit can well handle arrhythmias, cardiac and renal failure, and chronic lung problems of large children. The great majority of "in-betweens," however, are not dealt with well: e.g., the child with croup cannot be in the neonatal intensive care unit because of his contagion to relatively defenseless newborns, and is ill handled by an adult intensive care unit not used to small fluid, drug, and respiratory volumes.

A caveat needs noting: a PICU is not one simply by calling it so. Essential to its function are an adequately trained staff, physician in-house availability 24 hours a day, adequate monitoring equipment and laboratory backup, and people who "care intensively" at all levels. With this in mind we believe that the PICU, especially if regionally used, is likely to be more efficient and effective in handling severe pediatric disease.

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In a suit against a hospital and a medical group, the widow and sons of a patient who died as a result of allegedly negligent treatment, after he was admitted in a state of diabetic acidosis, received a settlement of $525,000.

The patient, who was 39 years old, was not unconscious when he arrived at the hospital. He appeared primarily to be suffering from a face infection after earlier dental surgery. When it was learned from his chart that the patient was a diabetic, treatment was begun for diabetic acidosis. In the middle of the night, the patient's condition suddenly declined. He went into shock, suffered a cardiac arrest, and died.

In a suit for negligence, the deceased patient's widow and sons contended that hospital employees did not take adequate measures to counteract dropping blood potassium, low blood carbon dioxide, and elevated blood sugar levels. Further, the patient was placed in a general ward rather than in an intensive care unit.

The widow said that her husband developed maturity onset diabetes four years prior to the admission in question. He reduced his weight by about 90 pounds, but his blood sugar levels were always elevated and his urine tests positive. The widow contended that the hospital was negligent in maintaining her husband on Orinase® instead of giving him insulin. The widow also contended that blood studies should have been performed more often than every four hours. She said her husband was never monitored by electrocardiogram and that instead of being seen intermittently by a physician, he should have received more intense observation.

The hospital contended that the deceased patient had a pituitary adenoma, which made him insulin resistant, and that he suffered from acromegaly. Contributory negligence was alleged in that he failed to tell his dentist that he was a diabetic. The hospital contended that it followed the standard of care at all times.—Scandalis v. Kaiser Foundation Hospitals (Cal. Super. Ct., Sacramento Co., Docket No. 221636, 1974)

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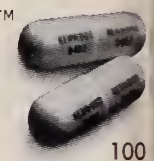

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Autogenic training, used extensively in Europe over the past 30 years, has been known to be effective in modifying the personality traits which predispose to coronary heart disease. More recently developed biofeedback methods enhance these changes. A training program combining these two methods is described and initial results are reported.

Autogenic Training and EEG Biofeedback Training in Coronary Heart Disease

E. S. Paul Weber, M.D./Princeton*

For quite some time, medical practitioners have been aware of a high incidence of coronary heart disease in certain personality types, which were studied and described first in the 1930's by Dunbar.[1] In recent years, Rosenman and Friedman have delineated a behavior pattern labeled Type A that correlates with a high risk of coronary heart disease.[2] That behavior pattern includes a combination of personality traits such as ambition and competitive drive, aggressiveness, impatience, a strong sense of time urgency, and a determination to persevere. At the other extreme, a behavior pattern called Type B, characterized by extreme passivity and lack of drive, was found to be less prone to coronary heart disease. It has been demonstrated, for instance, that in the thirty-nine to forty-nine-year age group the coronary disease risk of Type A was twice that of Type B, when serum lipids, blood pressure, smoking, obesity, and several other factors were held constant. Rosenman and Friedman concluded that emotional and behavioral factors lead to organic changes in coronary vasculature.

Even though the mechanism of such changes is not entirely clear, it has been shown that increased stress reactivity, through the intermediary of the hypothalamus, leads to increased serum cholesterol levels. In addition, the increased catecholamine discharge in Type A individuals could well intensify the atherosclerotic process. These findings raise the question of whether one could achieve a modification of behavior patterns such that this particular risk factor would be reduced or eliminated. Up to now the approach to this problem has been mainly through the use of tranquilizers and/or psychotherapy, the latter designed to increase the patient's awareness of harmful behavior patterns and to suggest specific changes. It often proves difficult, however, to bring about changes on the emotional level. In fact, the effort to desist from harmful activities can in itself often generate tension, anxiety and depression.

This paper describes the use of Autogenic Training and EEG biofeedback techniques which have been found to have a direct effect on the psychological risk factor. The techniques described find application to a larger spectrum of psychological problems, particularly those involving anxiety and tension. We shall confine ourselves here to the treatment of Type A behavior patterns.

The reasons that subjects of Type A come for psychiatric consultation vary. Those who are seen after a heart attack often come because of anxiety and depression related to concern about their heart. They cannot accept the need to slow down. The thought that they might have to accomplish less causes them to feel anxious and depressed. They often complain of psychogenic chest pains to a point of severe hypochondriasis, even after reassurance by their cardiologist that their pain is not organic in origin. On the other hand, Type A subjects, who have not had a heart attack, often come for consultation because someone close to them had a sudden infarct. Other

*Dr. Weber is a member of the attending staff at the Princeton Hospital, and is consultant to the Interdisciplinary Research Center of Rutgers University, where he formerly held the position of research associate.

patients come for consultation because they respond to a crisis on their job with a marked fear of failure and a sense of not being able to cope. They, too, show a mixed anxiety and depression, sometimes accompanied by hypochondriacal preoccupations. Some resort to alcohol for relief of tension, and this can lead to an escalation of their problems since the alcohol interferes with their efficiency and further increases their fear of failure.

Autogenic Training

Autogenic Training had its origin in the investigation of states induced by autohypnosis, and of their influence on psychophysiological functions. These studies were started by O. Vogt in Germany around 1900 and systematized in the late 1920's by G. H. Schultz, who also incorporated techniques derived from Eastern meditative practices.[3] The subjects are taught, in six consecutive standard exercises, to concentrate passively on the physical experiences of heaviness, warmth, calmness of the heart, calmness of breathing, warmth in the solar plexus, and coolness of the forehead. The learning of each exercise takes, on the average, a few weeks. At first, the state thus achieved was thought of simply as autosuggestive relaxation and was assumed to lie on the wake-sleep continuum, somewhere between predrowsiness and drowsiness. It is now conceived of as a specific psychological state, characterized by alertness combined with passivity, into which subjects learn to enter without passing through predrowsiness—called the Autogenic Shift.

Many studies over the years have shown the effects of Autogenic Training to be truly remarkable, despite the fact that only about five to ten minutes are devoted to the exercises three times daily. W. Luthe, who is well known for continuing Schultz's work, hypothesizes that "The therapeutic key-factor lies in a self-induced modification of cortico-diencephalic interrelations, which enables natural forces to regain their otherwise restricted capacity for self-regulatory normalization.[4]

The effects of Autogenic Training involve physiological and mental functions simultaneously. The physiological effects are diametrically opposed to changes elicited by stress. The effects during Autogenic exercises include increased peripheral temperature, a significant increase of the systolic-diastolic amplitude, slowing of heart rate and respirations, a decrease in muscle potentials and GSR, as well as changes in EKG (elevation of S-T segment and increase of T waves), and EEG (increased abundance of alpha activity and appearance of theta activity). After variable periods of practice of Autogenic exercises, there is a remarkable lowering of serum cholesterol, a tendency towards return to normal of high values of the PBI in hyperthyroid conditions, as well as a decreased need for insulin in diabetics. This latter effect is so pronounced that Autogenic Training in diabetics can be undertaken only under close medical supervision so as to avoid insulin shock. Gastrointestinal functioning is normalized as demonstrated by Cine-radiographic studies. Previously irritated or disturbed peristalsis becomes smooth. It is important to note, however, that if Autogenic exercises are discontinued, the serum cholesterol level returns to the previously high level over a period of weeks or months. This points to the necessity for continuing indefinitely with the exercises.

Similarly, the psychological changes induced by Autogenic Training can be interpreted as a reduction in stress reactivity. Gradually subjects learn to respond more appropriately to stresses both from external forces and from intrapsychic conflicts. These changes will be described in more detail later in this paper. This overview of the effects of Autogenic Training—particularly the reduction of stress reactivity and the lowering of blood pressure and serum cholesterol level—indicates that its application in Type A individuals should be useful.

EEG Biofeedback as a Supplement to Autogenic Training

Over the last ten years, it has been shown that most subjects can increase the amount and the amplitude of alpha waves (eight to thir-

teen cycles per second) of brain activity. In addition, more recent studies have demonstrated the possibility of increasing theta activity (four to eight cycles per second) in many subjects. The subjective states induced by increased alpha or increased theta have been described by numerous investigators. Increased alpha production corresponds fairly consistently to a subjective state of passive concentration or relaxed alertness. Theta activity has been related in some subjects to a state of relaxation with the appearance of visual imagery, which is now being investigated in its possible relationship to creativity. As yet, however, there have been no studies on the possible physiological changes during alpha and theta training sessions, nor are we aware of any investigations of physiological changes related to continued training, similar to the ones pointed out in regard to Autogenic Training.[5] Only one study indicating personality changes as a consequence of prolonged alpha training exists and this study did not include the examination of physiological variables.[6] Yet, after having observed the reactions of numerous subjects to alpha training, it appears that this method can supplement and enhance the effectiveness of Autogenic Training.

The equipment used provides auditory feedback for five channels of brain wave activity (mid-frontal, mid-parietal, mid-occipital, and left and right temporal electrode placements). The volume of the feedback tone varies with the amplitude of the waves produced, and subjects can be made to receive feedback from the five lobes either individually or simultaneously. Each biofeedback session lasts approximately forty-five minutes. Training consists in learning to increase alpha activity first, followed later by theta activity. A total of fifteen to twenty biofeedback sessions is suggested.

The reasons for adding EEG biofeedback training to Autogenic Training are as follows:

(1) EEG biofeedback increases motivation for continued involvement in the program. The experience of the close relationship between subjective states and such physiological manifestations as brain waves increases the realization of the direct connection between body and psyche. Similarly, during the second standard exercise of Autogenic Training, which involves the formula of warmth in arms and legs, patients are usually surprised when it is demonstrated with the feedback temperature meter that there is in fact an objective increase in peripheral temperature anywhere from two to ten or more degrees.

This question of motivation and attitude towards the program is most important. We have come to believe that our ability to influence directly our subjective states (the way we feel) and various physical manifestations (blood pressure, heart rate, temperature, and so on) is very limited. Thus, subjects who are told that their blood pressure is too high or that the pains they complain of are psychosomatic in nature or even that they are too tense or too competitive, consider themselves helpless to influence directly these experiences. A demonstration that shows that their influence over their body or their subjective states is more than they thought possible convinces them that they can take charge of a program for change and improvement.

(2) The state of passive concentration which is common to both the Autogenic Shift and to increased alpha production is achieved by most subjects more rapidly with the help of feedback. In addition, the possibility must be considered that EEG biofeedback training can increase the rate of progress.

EEG changes during Autogenic standard exercises have been studied fairly extensively.[7] There is general agreement about an increase in abundance of alpha rhythms as well as the appearance of theta waves, first anteriorly and then gradually generalizing in an anterior-posterior direction. Since alpha and theta production are enhanced with feedback training, one can assume that these two methods complement each other and one can expect that future studies will demonstrate that EEG biofeedback techniques increase not only the rate of changes brought about by Autogenic Training but the range and depth of effec-

tiveness as well. It should be noted, however, that the increase in alpha production with biofeedback training goes with an increase in alpha amplitude, whereas the Autogenic State is characterized by abundant low amplitude alpha, a difference which will have to be explored further.

(3) The Autogenic State enhances the effectiveness of autosuggestions and use can be made of organ-specific formulae directed at correcting specific physiological disturbances, as well as intentional formulae designed to bring about change in attitude and action. Similarly, one study by Budzynski indicates that subjects show increased suggestibility during the state of increased theta production with EEG biofeedback.[8] We have begun to make use of this observation to reinforce attitudinal changes and behavior changes which are considered desirable.

It is doubtful that EEG biofeedback training alone could be as effective as it is in combination with Autogenic Training. The daily exercises are very important, but we have found that the replication of the states achieved with biofeedback is difficult when the subjects are not receiving feedback. Also, Autogenic Training induces marked autonomic changes through the use of the six standard formulae previously mentioned. These autonomic changes are in the direction of parasympathetic activation. It is doubtful whether EEG biofeedback alone could be as effective in this dimension as Autogenic Training. Indeed, one can observe occasional subjects who produce abundant alpha in the presence of anxiety and tension. The use of Autogenic Training and EEG biofeedback could turn out to be complementary in that EEG biofeedback enhances relaxed alertness, whereas Autogenic Training increases autonomic relaxation.

Results of a Pilot Investigation

While we have observed good results in Type A subjects with Autogenic Training alone over a period of years, the addition of EEG biofeedback in twelve subjects appeared to increase motivation to stay with the program and to render treatment more effective. Of the twelve subjects, six had suffered a heart attack, the remaining six came for reasons similar to those mentioned earlier, without having suffered coronary disease.

The results were as follows:

(a) Eight subjects suffered various degrees of psychosomatic symptoms related to their heart, such as chest pains, a feeling of constriction in their chest, and so on. These symptoms cleared.

(b) Anxiety, tension, and depression gradually subsided.

(c) In six subjects, slightly elevated blood pressures (systolic varying between 155 and 175, diastolic varying between 98 and 110) returned to normal.

(d) Changes in behavioral patterns became apparent. These are summarized as follows:

(1) In type A subjects the tendency to persevere, mentioned by Roseman and Friedman, relates to an inability to let go of a task once involved in it. The subjects are, as it were, slaves to their activities. This can be a consequence of excess stress reactivity which lacks modulation. Subjects in training noticed that they developed more flexibility—that is, that ability to shift attention more easily from one endeavor to another.

(2) Type A subjects constantly seek activity: It is as if their hyperaroused state constantly asked for outlets. At the same time, they show a lack of discrimination between important and less important endeavors and often end up feeling that, in important areas, they accomplish much less than they feel they could. With training, subjects gradually develop a sense of what is important and do not get sidetracked by the less important.

(3) Concurrently, Type A subjects develop a reduced sense of time urgency, an increased sense of self assurance, and lessened aggressiveness and competitiveness. Very often subjects feel that they are more productive despite the fact that it seems to require less energy. In addition, it has been observed that subjects find closer involvement with some people and more detachment from others. Here, too, there is increased selectiveness.

(4) These changes add up to an increased sense of relaxation and well being.

Outline of the Treatment Program

It is important that the program be explained, not as psychiatric treatment, but rather as a form of psychological training. Type A subjects are often concerned about their self image—in part because of their competitiveness. The goals of behavior changes that can be expected are described so as to produce good motivation. A written outline of the program is offered, which includes a schedule of biofeedback sessions and Autogen-

ic Training instructions, periodic behavior assessments, blood pressure and cholesterol readings, and peripheral temperature measures. There is a final evaluation after sixteen to twenty biofeedback sessions. A progress sheet listing these items is kept on each subject and shared with them. In addition, time is offered for consultations about specific problems.

At the end of the program, after subjects have learned this skill, they are advised to continue practicing it indefinitely. Eventually this requires little time, about five minutes three times daily. Most subjects find it pleasant and helpful, and they enjoy continuing with the practice. At times they remain in the Autogenic State for longer periods of time, perhaps fifteen to twenty minutes. Also, toward the end of the training, they are instructed in the use of the Autogenic State as a means to implant positive suggestions.

Conclusion

Even though detailed studies will be necessary to delineate the changes resulting from this program of combined Autogenic Training and EEG biofeedback training as applied to individuals prone to coronary heart disease, the literature in existence on Autogenic Training, as well as our experience with biofeedback training, strongly indicates that changes observed already fully justify its systematic use in this type of problem. The training is to be considered not as psychiatric treatment but rather as the learning of a skill. At a time when coronary heart disease is on the rise and is becoming more common in younger subjects, this method, which will undoubtedly be developed further in the future, offers a counterbalance to stress forces resulting from external as well as internal pressures.

Footnotes

[1]Flanders Dunbar: *Psychosomatic Diagnosis*. New York, Harper, 1943.

[2]Rosenman R H and Friedman Meyer: The central nervous system and coronary heart disease. *Hospital Practice*. October 1971, pp. 87-97.

[3]The use of Autogenic Training has spread from Western Europe to many other countries, particularly Japan. It is finding increasing application in the fields of education and sports. There exists now an International Research Organization for the Application and Teaching of Autogenic Training.

[4]Wolfgang Luthe, ed: *Autogenic Training: Correlationes Psychosomaticae* New York and London, Grune & Stratton, p. 48.

[5]The physiological effects of electromyographic and temperature biofeedback training are being studied extensively at present. No similar studies have been reported in regards to EEG biofeedback training.

[6]L G Fehmi: The effects of EEG biofeedback training on middle management executives. A paper delivered before *The Biofeedback Research Society* in Colorado Springs, February, 1974.

[7]Wolfgang Luthe: *Research and Therapy*. New York, 1970, pp. 79-118, Vol. 4 of *Autogenic Therapy* (New York, 1969-70).

[8]T H Budzynski and K E Peffer: Twilight state learning: the presentation of learning material during a biofeedback produced altered state. A paper delivered before *The Biofeedback Research Society* in Colorado Springs, February, 1974.

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*Morris Fishbein, M.D.: In *Medical Writing*, 4th edition. Springfield, Illinois, C. C. Thomas, 1972.

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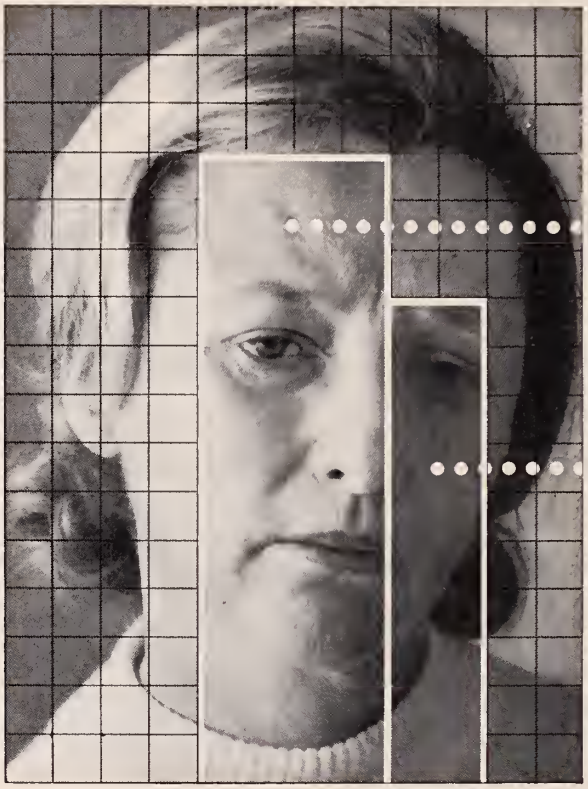

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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

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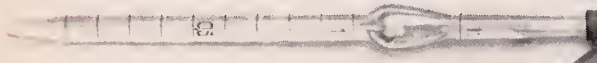

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There are many successful and unsuccessful methods of controlling conception presently in use and a large potential for many more in the future. Aside from the mechanical techniques, whose modus operandi is obvious, the accepted and/or hypothetical explanations for the effectiveness of each are described. The real and potential complications and side-effects are also documented by the authors.

Contraception

A Survey of the Literature: Past, Present, and Future

Anthony C. Quartell, M.D., Caterina A. Gregori, M.D. and James L. Breen, M.D./Livingston*

In the time that it takes to read this paper, the population of the planet Earth will increase by approximately 9,000 to 10,000 people. These figures, of course, cannot be stated accurately, but, according to the United Nations, the world population (which was 3.7 billion people in 1971) will rise to between 4.4 and 5.0 billion people by 1980.

Among the causes of this enormous growth of population are:

1. The diminution of the death rate, due to better standards of health, nutrition, and living.
2. Improvements in sanitation and increased productivity in some of the more underdeveloped countries.
3. The technical advances in medicine, agriculture, and nutrition of the 20th Century.

Faced with these awesome numbers, the search for a safe, effective means of conception control takes on a new and much wider importance. The practicing obstetrician-gynecologist assumes (willingly or not) the position of a primary conception control physician. He is asked to make decisions involving a method of conception control for patients desirous of preventing the birth of unwanted children.

The plethora of new types of birth control methods, variations on some of the old chemical themes, and the tremendous amount of research-time and money that have been spent on conception control are witness to the fact that the "ideal" method of birth control has not been found. It is the purpose of this paper to describe the status of contraception in 1973, with reflections on its past, and predictions of the future.

History

Coitus interruptus, or withdrawal of the penis prior to ejaculation, is probably the oldest successful contraceptive procedure known to man. It was used by ancient tribesmen of the Middle East and is referred to in the Old Testament.

Egyptian women inserted pessaries made of crocodile dung and honey or used vaginal tampons of lint soaked in Acacia juice.[2] The earliest recorded intrauterine device also belongs to ancient Egypt; however, since it involved the insertion of stones in the uteri of camels to prevent pregnancies during safari, it does not qualify as a human technique.

In 1928, a Berliner, Ernst Grafenberg, improving on an earlier (silkworm gut) design of Richter, created a silver coil IUD.[2] It was used briefly in pre-war Germany, but fell into disuse rapidly. During the 16th century, the famous Italian anatomist, Fallopious, devised a linen sheath for the penis. Intended for the purpose of preventing the spread of syphilis, it was not widely accepted. Other models, devised of sheep cecum and later made from rubber, became more popular. It is estimated that between 700 and 800 million condoms

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are produced annually in the United States. Among the many quotable quotes regarding this device, two merit mention:

Madame de Sevigne, in a letter to her daughter in 1671, referred to the condom as "an armor against enjoyment and a spider web against danger".[2]

Cassanova, in his "Memoires," indicates he used condoms both as a prevention against venereal disease and as a contraceptive. His opinion of them is summed thusly—"I do not care to shut myself up in a piece of dead skin in order to prove that I am alive."

These are but a sampling of the efforts of ancient man to control the quantity of his offspring. It is obvious that newer and more successful methods of conception control are available to modern man. Indeed, Kistner refers to the years 1960-1970 as "the decade of control—conception control."[2] Considering that the last state law prohibiting the use of contraceptives was overturned in the U.S. Supreme Court in 1965 (Griswold vs. Connecticut), this may not be far from the truth.

Methods of Measuring Effectiveness

Even a casual perusal of the recent literature involving methods of birth control will leave the reader perplexed by the number of definitions, statistical gyrations, and ratios that are used to describe the effectiveness of a contraceptive. The theoretical effectiveness of a contraceptive, that is, the antifertility action under ideal conditions of use, is very difficult to measure because of the human error involved. Researchers in most field trials seem to have settled on *Use Effectiveness* as the indicator of choice. If a given method is used by 100 women, and then the number of pregnancies in that group are recorded for a one-year period of time, the number arrived at is the use effectiveness of that method. In other words: Use Effectiveness or R = Pregnancy rate per 100 women years. This number can be simply calculated by the following formula:

$$\text{Use Effectiveness or } R = \frac{\text{total number of conceptions} \times 1200}{\text{total months of exposure}}$$

(in order to be arithmetically correct, the investigator must subtract 10 months (for each pregnancy) and 4 months (for each abortion) from the denominator).

With no contraception, R is about 85; using methods of even the lowest effectiveness bring this number to 40. In general, coitally-related months of contraception yield an R of between 6 and 35 pregnancies per 100 women years. Intrauterine devices (IUD's) are responsible for R's of between 2 to 4 pregnancies per 100 women years (however, with an overall expulsion or removal rate of around 25 percent, this failure rate becomes spurious.) Oral contraceptives are the most effective with R's of between 0 to 2 pregnancies/100 women years. A rough outline of the various use effectiveness rates of most major methods of contraception follows. (Table 1)

Table 1

	Lowest in large studies	*Highest in large studies*
None	75	100
Coitus interruptus	20	35
Douche	20	30
Rhythm	14	25
Foam (spermicidal)	10	20
Jelly (spermicidal)	8	15
Condom	10	16
Diaphragm	10	18
Diaphragm with jelly	6	15
IUD	2	4
Oral contraceptives		
sequential	1	2
combined	0.1	0.8

Currently Available Methods of Contraception

This discussion includes virtually all methods of contraception in use today. The kinds of contraceptive methods discussed in this paper are methods which temporarily and reversibly prevent coitus from resulting in pregnancy. The permanent means of contraception in use today are almost exclusively surgical procedures. It would be beyond the scope of this paper to include methods of permanent sterilization. Methods involving interference with fetal survival after implantation are also excluded.

Coitus Interruptus

Withdrawal or coitus interruptus is defined as

the removal of the penis from the vagina prior to ejaculation. While this is an old, accepted method of birth control, several difficulties are inherent in its practice.

Sperm cannot only survive but may succeed in fertilizing the ovum if implanted into a suitably moist environment. During intercourse, the external genitalia are sufficiently moistened by coital secretions to allow sperm to migrate into the vagina. Thus, it is necessary for the couple engaging in this method of contraception to take special care that ejaculation does not occur on or near the external genitalia. Coupling this problem with the fact that viable, motile sperm can be found in pre-ejaculatory urethral secretions makes the withdrawal method one of the least secure methods of contraception.

Coitus interruptus also relies on an extremely variable parameter of human nature; namely, withdrawal before ejaculation depends on a man's ability to perceive that ejaculation is imminent. These problems are reflected in the high failure rate of this method of contraception. With coitus interruptus R averages between 20 and 35 pregnancies per 100 women years. It does not seem to be a very popular method of contraception in the United States, but withdrawal is practiced widely in many countries of Europe and the near East.[4] Its use is described as being inversely proportional to the socio-economic status of the family.

Prolonged Lactation

It is a well-known fact that women are less likely to conceive after childbirth if they breast feed their babies.

Postpartum amenorrhea is prolonged, and in some cases, ovulation can be delayed by prolonged breast feedings; however, these undesired effects are unpredictable and ovulation can return while the woman is still amenorrheic. Breast feeding is the rule rather than the exception in many underdeveloped nations. To some extent, this must delay conception whether intended for that purpose or not.

Condom

By providing a mechanical barrier between the penis and the vagina, the condom prevents deposition of sperm into the vagina. Prior to the introduction of oral contraceptives, the condom was the most widely used method of contraception in the United States. In a 1955 survey, 27 percent of all couples practicing contraception used this method, but 10 years later (and about 5 years after "the pill") this number had dropped to 18 percent.[4] The condom also provides a reasonably adequate protection against venereal disease and is used extensively by the United States Armed Forces for this purpose. Most failures while using the condom method of contraception are due to one of the following factors:

1. Since it is known that impregnation can occur not only from premature ejaculation, but also from the sperm present in pre-ejaculatory urethral secretions, it is important to stress to patients that the condom is only effective if used *throughout* intercourse rather than just prior to ejaculation.

2. Because of loss of erection following ejaculation, semen may leak out at the open end of the condom.

3. Pregnancy may result from a break or tear in the condom.[4] This has been estimated to occur once in 150 to 300 instances. New developments in condom technology are rare, but a plastic condom has recently been developed. Its major advantages are cost, ease of manufacturing, and unlimited shelf life.

However, the most common cause of failure with this, and the rest of the mechanical barriers which must be applied in some manner to the genitalia before intercourse is simply the failure of the participants to use them. It has been estimated that the risk of pregnancy from a single unprotected episode of intercourse, occurring randomly in the menstrual cycle, is between 2 and 4 percent.[4]

The Diaphragm and Spermicidal Preparations

Since its invention by the German physician, Wilhelm P. J. Mensinga, in 1882, the diaphragm has remained relatively unchanged. It consists of a metal spring, circular in shape, covered by a dome-shaped latex rubber membrane. The diaphragm is inserted into the vagina by the patient. In its proper position,

resting anteriorly against the soft tissues posterior to the symphysis pubis, and posteriorly within the posterior vaginal fornix, it acts as a mechanical barrier to the passage of sperm through the cervical os. When used regularly in connection with a spermicidal cream or jelly, this method offers a high level of pregnancy protection, with a failure rate R of between 2 to 3 pregnancies per 100 women years. However, because of the inconvenience involving its use, the above failure rates are not always the case, and the use effectiveness rates of between 10 and 20 pregnancies per 100 women years seem to more accurately represent diaphragm failure rates.

This device must be fitted by a qualified physician. It also requires a high degree of motivation, and is easily abandoned by many couples.

Spermicidal creams, jellies, or foams have been developed for use with or without the diaphragm. Each of these preparations consists of two components: (1) A spermicidal chemical, usually a complex analogue of ethanol and (2) A nonreactive base.

The action of these preparations is twofold, besides the expected spermicidal activity, these agents are also effective as mechanical barriers to the passage of sperm. The use of these preparations is of little importance in the United States contraceptive picture as of 1973. Foams seem to be the most popular, and because of their "staying power" probably the most effective. Failure rates of between 8 and 20 per 100 women years have been recorded.

There have been recent reports of the use of a two-inch square plastic film which can either be inserted into the vagina, or introduced vaginally atop the glans penis. This film contains a spermicidal agent; there is no data indicating the effectiveness of this method, but it would probably be no better than the spermicidal preparations presently marketed.

Disadvantages of these methods are reluctance of patients to use them because of "messiness" and the inadequacy of the quantity of the spermicidal preparations at the cervical os due to redistribution among coital motions.

Rhythm

The avoidance of intercourse during the fertile period of the menstrual cycle ("rhythm") is a very old, and time-honored practice. The calendar rhythm method was developed independently in the 1920's by Ogeno in Japan and Knaus in Austria. Although there is no precise way to determine exactly when ovulation occurs, the calendar rhythm method relies on the following calculations. After recording her menstrual cycles for one year, the number 18 is subtracted from the shortest cycle and 11 is subtracted from the longest cycle. The days between are considered the fertile period. For example, a woman whose shortest cycle was 21 days, and whose longest cycle was 35 days would have a "fertile period" between day 3 and day 22. Obviously, this degree of sexual abstinence is disagreeable to many couples. Under the best of circumstances, with well motivated subjects, this method yields a failure rate of between 14 and 16 per 100 women years.

Another method of calculating the exact time of ovulation is to measure the shift in basal body temperature observable during the middle of an ovulatory cycle. This shift consisting of a temperature drop followed by a temperature rise occurs during ovulation.

This method is also fraught with problems, the temperature drop is of a very short duration, and in some women, daily temperature recordings may be spaced too widely apart to record this. Since the theoretical period of sperm survival is about 48 hours, and ovum survival about 24 hours, it is evident that conception can take place if coitus occurs within 72 hours following the beginning of the rise in basal body temperature.[5] The "safe" period consequently begins with the fourth day after the rise in basal body temperature and ends with the fifth day following the onset of the next menstruation. The effects of a simple viral upper respiratory infection upon this delicate balance are devas-

tatingly apparent. The rhythm method is still the only method of contraception officially sanctioned by the Catholic Church. Its use by Catholics has been reported to be inversely proportional to the socio-economic status of the household, and to the number of children residing therein.

A survey in 1955 revealed that rhythm accounted for one-half of all contraception practiced by Catholics in the United States; by 1965, that number had declined to one-third.

Oral Contraceptives

The attempts of mankind to control fertility by the ingestion of foreign materials are legion. A list of the more interesting ones includes: willow leaves, iron rust or slag, clay, mule kidney, and the uterus of a female mule.

In 1942, Sturgis and Meigs while searching for a menstrual suppressant noted that estrogen in daily oral doses could inhibit ovulation. This was utilized as a treatment for endometriosis, but not as a contraceptive because the prolonged use of relatively high dose estrogens without progesterone led to endometrial hyperplasia.

If it is at all possible to place the title, "Father of the Pill," on any one man or group of men, it goes to the late Gregory Pincus and John Rock who described their first successful clinical trials in 1958.[7,8] The U.S. Food and Drug Administration approved "the pill" in 1960 after three to four years of extensive clinical trials.

With the exception of antibiotics, no single pharmaceutical product has affected the way of life of our world population as much as "the pill." Approximately ten years after its introduction, the twenty different varieties of oral contraceptives made in the United States accounted for about 8.5 million cycles per month.[9] The grand total of "pill" users in other countries doubles this figure when one counts for worldwide use.

A very important parameter in the success or failure of a contraceptive is the continuation rate, or the proportion of patients still using a particular method of contraception after a given period of time, i.e., one or two years. Some national surveys have found this to stay close to 80 percent for one year and about 73 percent after 24 months with "the pill."[4] These same surveys also show that continuation rates are higher among younger and more educated women. "The pill" has been the leading method of contraception among American women for at least ten years.

Chemical Makeup and Function

Most of the oral contraceptives on the American market today consist of a synthetic estrogen and a synthetic progesterone, either taken in combination for 21 days, resting 5 to 7, or taken sequentially utilizing estrogen alone for 15 or 16 days, followed by a combination of estrogen and progesterone for 5 days.

Of the synthetic estrogens, the most popular are mestranol and ethinyl estradiol. The most popular synthetic progestins are norethindrone, norethynodrel, methoxyprogesterone acetate and norethindrone acetate.

These compounds suppress ovulation by inhibiting pituitary secretion of the gonadotropins, specifically follicle stimulating hormone and leutinizing hormone. Direct examination of ovaries during laparoscopy and operations on women taking oral contraceptives have revealed the absence of newly formed corpora lutea. Urinary pregnanediol levels do not exceed 0.50 mg/day during the expected postovulatory period with patients taking oral contraceptives. At this time in the cycle in normal women, they may go as high as 5.0 mg/day.

Hypotheses that the standard estrogen progesterone pill prevents conception by other methods, such as the alteration of cervical mucus or endometrial changes, have not held up in well-documented studies; these actions do seem to be responsible for the effects of other oral contraceptives, which will be discussed later.

Side Effects and Selection

The milder "annoyance" side effects seem to be dependent upon the relative amounts of progestin and estrogen in the particular pill selected. Estrogen is a gastric mucosal irritant in some women and is also responsible for decreased sodium excretion by the kidney. These account for its major "annoyance" side effects, namely, nausea, weight gain, a "bloated" feeling, and headaches, which may be due to a mild cerebral edema. Kistner believes healthy, robust, full-breasted young women who menstruate and ovulate normally do best with a progestin dominant pill. On the other hand, an estrogen dominant pill is better for the tall, thin woman with small breasts and scant menses.

The overall effect of each of the combined pills depends upon their relative content of progestin and estrogen-like substances. Since the side effects of these hormones are antagonistic, one can gain a desired effect by increasing the estrogen content or decreasing the progesterone content of a pill. (Table 2).

Table 2—Relative Estrogen-Progestin Content

	Trade Name	*Progestin*	*Estrogen*
Highest Estrogen Effect	Enovid E®	Norethynodrel	Mestranol
	Enovid®	Norethynodrel	
	Ovulen® group	Ethynodiol Diacetate	Mestranol
	Norinyl® group	Norethindrone	Ethinyl
	Norlestrin®	Norethindrone Acetate	Estradiol Ethinyl
	Ortho Novum® group	Norethindrone	Estradiol Mestranol
Highest Progestin Effect	Ovral®	Norgestrel	Ethinyl Estradiol

This simple relationship is complicated by other factors. Some of the progestational compounds (norethynodrel, norethindrone, and ethynodiol, all 19 non-steroid compounds). are at least partially metabolized to estrogen.[2] Norgestrel (the progestin in Ovral) ® actually possesses some anti-estrogenic qualities of its own.

These preparations come in varying strengths; there is considerable overlap in the groupings.

"The pill" is far and away the most effective of the methods of contraception in use today. Tietze, reporting on some 325,000 cycles of medication at the Fifteenth Nobel Symposium, found only 17 pregnancies which were not associated with the omission of a tablet or two.[10] (R) is calculated as being near 0.1 to 1.0 pregnancies per 100 women years in many studies.

Although a plethora of minor side effects have been "blamed" on the pill, there is little scientific evidence to support them. Besides the nausea, headaches, and weight gain already discussed, breakthrough bleeding, chloasma, breast engorgement and discomfort seem to be causally related.

The Pill and Thromboembolic Phenomenon

In 1968, two British researchers, Inman and Vessey, published an article on preliminary investigations into the relationship between the pill and deaths from pulmonary, coronary, and cerebral thrombosis based on a retrospective analysis.[11,12] They studied the use of oral contraceptives by 84 women discharged from the hospital with a diagnosis of thromboembolic disease during the years 1964-1967. In a separate study, 97 women treated for thromboembolic disease were also studied with matched control patients. These studies were performed to see if there was a signifi-

cant relationship between oral contraceptives and thromboembolic disease.

Briefly, the results were as follows: Of 84 patients with deep vein thrombosis, or pulmonary embolism, 42 or 50 percent had used oral contraceptives in the month before onset of the disease. On the control side, 23 of 168 controls or 14 percent had used oral contraceptives. All patients were matched for age, height, weight gain, smoking habits, and any other parameters which have been shown to affect thromboembolic disease. Of 19 patients with cerebral thrombosis, 11 or 58 percent had been using oral contraceptives. Of 38 controls (patients not on "the pill") only 3.5 percent developed any thromboembolic phenomena. Coronary thromboembolic disease did not seem to have a relationship to using "the pill". Vessey and Doll, therefore, concluded that "the new evidence strengthens the belief that oral contraceptives are a cause of venous thromboembolism and cerebral thrombosis."[12]

In his 1972 paper, Drill reported on *prospective studies* involving over 80,000 women receiving oral contraceptives for more than 1,000,000 cycles. He found that the "average normal" rate of superficial and deep vein thromboembolic disease in women of childbearing age was 2.2 cases per 1,000 women years. Drill also found that the rate of superficial and deep vein disease is 0.97 cases per 1,000 women years in matched controls not taking any medications, concluding that "the incidence of this (thromboembolic) disease is not increased during pregnancy, when estrogen secretion is increased, *or when oral contraceptives are employed.*" Although thromboembolic disease is increased in the postpartum period, Drill stated that it is not increased during pregnancy.

This author concluded that the retrospective studies showed a *relationship* between the pill and thromboembolism, but that they were not designed to measure the *incidence* of the disease. The study can only suggest that an association exists between A and B but it cannot establish a cause and effect relationship.

Drill and his collaborators continued to give estrogens to patients with thromboembolic disease and found that their patients achieved complete recovery while still taking the "pill." In an effort to establish a relationship between the dosage of estrogen and the incidence of thromboembolic disease, Drill reviewed studies of more than 70,000 patients in a second paper.[14] As would be expected from his previous work, no dose relationship was found between estrogen and the incidence of thromboembolic disease. The recent literature seems full of articles taking one side or the other in this "great debate." That a relationship between "the pill" and thromboembolic disease exists seems a reasonable supposition, but exactly what that relationship is remains to be seen.

Oral Contraception and Cancer

Oral contraceptives have also been implicated as a causative factor in several types of cancer. Many studies of patients with neoplastic cells on Papanicolaou smears were matched against controls from the same general background. No relationships were found between "the pill" and squamous dysplasia or carcinoma. In one particular review of 200 patients, matched for age, ethnic background and age at first coitus, it was also found that "patients with cervical carcinoma had not used oral contraceptives to a greater extent than did control patients." This study lasted five years.[16]

A 1969 survey of a Planned Parenthood group in New York City did show a 5 percent increase in the incidence of cervical carcinoma in women taking "the pill" as compared with controls using the diaphragm method.[17] This is obviously a relationship requiring further elucidation.

Although several studies are now in progress, there does not seem to be any cause-effect relationship between "the pill" and breast cancer in humans. Some workers, however, feel that giving "the pill" to patients who already have breast cancer may stimulate the rate of growth of the malignancy.

There has been a latency period of at least a decade between the appearance of other carcinogenic drugs on the marketplace, and the appearance of reports linking them to cancer. It seems that the present studies involving "the pill" are still too early to either prove or refute a direct relationship between "the pill" and cancer.

Oral Contraceptives and Future Generations

There does not appear to be any decrease in fertility in women who have taken oral contraceptives and then stop for a desired pregnancy. While no increase in gross congenital malformations has been noted in their offspring, there have been reports of chromosomal abnormalities (polypoidy) in aborted embryos of women conceiving within six months of cessation of oral contraceptives.[18] In a brief study of peripheral blood lymphocyte cultures, "no significant change in chromosome breaks or mitotic index was found" when comparing the same women before and after taking "the pill."[19]

Biochemical Effects of Contraceptive Drugs

Table 3 summarizes the effects of "the pill" on various biochemical and physiological parameters.

Table 3[1] *Biochemical Effects of "The Pill"*

Elevated with "the pill"	*Lowered with "the pill"*	*No change with "the pill"*
Glucose levels (blood)[20] in a 1-hour GTT	Growth hormone[21]	
Plasma Glucocorticoids[21]	Tryptophan Metabolin[25]	Spirometry Values[23]
Serum Pyruvate[21]		Lactation[24]
Non esterified fatty acids[21]	Vitamin B_6[26]	Magnesium, zinc and calcium in cervical mucus[22]
Potassium and chloride in cervical mucus[22]		
Serum Copper[26]	Folic Acid[26]	
Ceruloplasmin[26]	Vitamin B_{12}[27]	
Vitamin A[26]	Glucose Tolerance[3]	
Plasma Renin Substrate[26]		
Plasma Renin Activity[28]		
Aldosterone Excretion[28]		
Liver BSP Retention[21]		
PBI[3]		

Intrauterine Contraception

Although medical history is full of attempts at intrauterine contraception, the first of the modern day intrauterine devices was not introduced until pre-World War II Germany. The Gräfenberg ring, originally made of silkworm, was later constructed of silver wire. Although it was initially popular, it fell into disrepute and its use dwindled, largely because it was associated with previous IUD's which the majority of gynecologists had rejected due to resultant pelvic inflammation.

In the early 1960's, the IUD reappeared, first in Japan and later in field trials in the United States under the auspices of the Cooperative Statistical Program.[29] The modern IUD comes in a variety of shapes and sizes. Manufactured from teflon, polyethylene, and stainless steel, many are capable of being compressed or elongated for ease of passage through the minimally dilated cervical os. Once inside the uterus, it returns to its original shape.

Mode of Action

The presence of a foreign body in the uterus causes an inflammatory response, with a polymorphonuclear cell infiltrate, and an inflammatory transudate which can be seen weeping from the endometrial lining. This environment is hostile to the viability and motility of spermatozoa and to the viability of the fertilized ova. Recent studies have shown that the addition of copper to an intrauterine contraceptive device will enhance the efficiency of the IUD. Spectrophotometric measurements have been taken after immersion of purified copper in chelated solutions of substrates. Within two hours cupric ions, which were liberated from the foil, inactivated sperm which had been incubated with midcy-

cle cervical mucus. The effect of copper upon human uterine and cervical secretions was to cause the secretions to thin out and become cloudy by reduction of disulfide bonds in the proteins and mucins of reproductive secretions. Thus, albumin was precipitated in the uterine wall. Also, the fission of disulfide bonds was thought to lyse sperm transport vehicles, inactivating carbonic anhydrase and alkaline phosphatase—both essential to reproduction. The fate of cupric ions liberated by the copper IUD's is not known; however, their complete systemic absorption would increase the serum copper concentration by one percent per day; this has not been observed.

When copper was added to the well known Lippes loop (type A), it had the effect of reducing spontaneous expulsion rates with this IUD. This apparently beneficial result must be balanced by an increased removal rate by physicians due to pain and bleeding. Failure rates were somewhat lower with the copper impregnated Lippes loop than with a similar loop without copper.[31] Probably more important, the intrauterine devices can no longer be regarded as inert uterine foreign bodies, but can be used as vehicles to carry into the uterine cavity many pharmacological agents capable of impeding the process of conception.

Effectiveness

In a four year prospective study at a California medical center, 2,547 IUD insertions were made in 2,300 patien's.[32] (These IUD's contained no antifertility agents.) This is probably the largest prospective study in the recent literature. While most of these insertions were made in the immediate postmenstrual phase of the cycle, some were inserted during menstruation, and almost 400 immediately postpartum. Patients were then evaluated six weeks after insertion and yearly after that. Using a variety of IUD's (coils, bows, and Lippes loop), the (R) or failure rate was 3.4 pregnancies per 100 women years. Post delivery insertion, however, yielded a dismal 19.3 percent expulsion rate. Failure rates were not related to parity or the type of IUD used.

Side Effects

The most common complaints of women with IUD's are bleeding or spotting, and pelvic cramping and pain. Bleeding occurred in almost 25 percent of patients in the Stanford study.[33] These symptoms usually resolve spontaneously in the first few weeks to months after insertion; however, persistence of these symptoms is the main reason for the removal of intrauterine devices. Although the onset of pelvic inflammatory disease (PID) has been attributed to the insertion of IUD's, most of these episodes have been interpreted as the "re-activations of pre-existing chronic or subacute conditions brought on by the insertion of the IUD," rather than new infections.[32]

Production of pelvic inflammatory disease in women with healthy pelvic organs by the insertion of the IUD in competent hands has not been reported in the literature. In most cases of PID among patients wearing an IUD, the infections are relatively mild and can be treated successfully without removal of the device. However, deaths attributed to PID associated with intrauterine devices have been reported in the United States. In four of ten reported cases, it was strongly suggested that the insertion of the IUD may have been the precipitating cause of the fatal illness.[33]

Perforation into the peritoneal cavity is obviously one of the more dramatic complications of the intrauterine device. Most perforations occur asymptomatically at the time of insertion.[35] The incidence of these accidents is very low (1 in 2,500 insertions is an average of most types). The accepted practice among present day obstetrician-gynecologists is to remove the perforated IUD from the peritoneal cavity regardless of the absence of symptoms, since the greatest complication of IUD displacement is pregnancy.

The physician must first detect the position of the displaced IUD, and ultrasonography has proved a very useful tool for this purpose, whether the device is inside or outside the uterus.[34] The routine use of ultrasound scanning has been suggested in these cases to spare women the discomfort of hysterography.

Once the displaced IUD is located in the abdominal cavity, the preferred method of removal is laparotomy, although laparoscopic removal has been reported in the literature.[35] Of six IUD's removed through the laparoscope in a study at the Medical College of Wisconsin, four were coincidental findings at the time of laparoscopic sterilization.[35] Five of the six displaced devices were Lippes loops.

In an effort to reduce the number of spontaneous expulsions, a nickel-chromium stainless wire device, commonly referred to as the Majzlin spring, was developed in the late 1960's. It is mentioned here only to condemn its use. In many studies, it was found that the excessive bleeding and pelvic pain involved with its use far outweighed any advantages. Of over 400 Majzlin springs inserted in a study at the University of Texas, 22 percent had embedded themselves in the endometrium far enough so that their removal proved very difficult. About 15 percent were removed vaginally with pieces of endometrium still attached to one or more of the loops; while 4.2 percent could only be removed by laparotomy. From these experiences, it was concluded that "the potential for significant complications from the continued use of the Majzlin spring was so great that it would no longer be inserted, and those already in place would be removed."[36]

Ectopic Pregnancy

It has long been suspected that the IUD would be responsible for an increased incidence of ectopic pregnancies and in several studies, an unusually high ratio of ectopic to intrauterine pregnancies in IUD wearers was noted. Ratios as high as 1 in 30 pregnancies were found. This may represent the simple fact that IUD's are effective in preventing intrauterine implantation, but have little effect on implantation outside the uterus. A high index of suspicion of ectopic pregnancy is necessary for the pregnant patient whose history includes the use of an IUD at the time of conception.[37]

The question of what to do with the patient who has an IUD, becomes pregnant, and is desirous of retaining the pregnancy is debated in the literature. Although many authors recommend leaving the IUD in place, it has recently been shown that the IUD which has a tail (part or suture) protruding from the cervical os, and which comes through the os easily with gentle traction can be removed before the fourth month of gestation with perhaps some decrease in the rate of spontaneous abortions.[38]

A case of cardiac arrest at the time of intrauterine contraceptive device insertion prompted several U.S. Navy physicians to do a study on electrocardiogram changes at the time of insertions.[39] These researchers found electrocardiographic changes in 29 of 87 patients tested; 12 patients had tachycardia of over 120 beats/min. Eleven patients had significant bradycardia with the inclusion of supraventricular conducted beats, paroxysmal ventricular contractions, and the reported one cardiac arrest (successfully resuscitated). It was suggested by these authors that the more "nervous" type of patient, those with very low thresholds of pain, and those patients prone to "fainting spells" are the patients most commonly predisposed to arrhythmias during IUD insertion.

The Mini-Progesterone Pill

During studies with the standard low dose estrogen-progesterone pill, it was found that ovulation occurred in a surprising number of cases, despite the fact that the antifertility effect of the drugs was still high. It was concluded that perhaps other mechanisms besides ovulation suppression were also responsible. This conclusion stimulated work on a new type of pill, the "Mini-progesterone" pill, first described by Rudel.[40] Further studies by Segal, Moghissi and others indicate that the "mini-pro pill" is effective, although some complications are more common with its use. Dosages of these pills are extremely low, an example being a norethindrone tablet marketed at the present time containing only 350 micrograms of norethindrone. The main complication of these pills is the increased incidence of irregu-

lar menstrual bleeding. Breakthrough bleeding which evidently occurs only when ovulation is suppressed, happens in 20 to 25 percent of cycles of microdose progestins.[42] The effectiveness of these microdose progesterone pills yields an (R) or failure rate of about 2 to 7 pregnancies per 100 women years, placing them behind the combination estrogen-progesterone pill and the IUD in effectiveness. Although the exact mechanism of action of the "mini-pro-pill" is unknown, several researchers suggest that there are a variety of modes.[42,4] These include:

1. Alteration of the physical, biochemical, and biological properties of cervical mucus with inhibition of sperm penetration and motility.

2. Disturbances of the hypothalamic-pituitary axis

3. Endometrial changes which would prevent implantation

4. And, in some cases, the inhibition of ovulation

The best documented and by far the most interesting of these are the changes induced in cervical mucus by this pill. The expected midcycle changes in cervical mucus are completely reversed in patients taking this medication. There is a "significant decrease in the amount and spinnbarkeit, and an increase in the viscosity and cell count during treatment with microdose progestins.[42] Sperm penetration (when measured *in vitro*) was significantly inhibited in this "hostile environment." Sperm that do manage to penetrate the mucus seem to have altered motility and exhibit circular patterns of motion not commonly seen in normal spermatozoa.

Hormonal changes induced by the "mini" pill included significant suppression of preovulatory follicle-stimulating hormone and leutinizing hormone peaks, variable alterations in the urinary estrogens, and marked suppression of progesterone production during the luteal phase. The endometria of patients taking these pills show a mixed phase endometrial picture with "glandular atrophy, compact stroma, absent or focal stromal edema, fibrosis, and a moderate decidual reaction."[42] This histological pattern is somewhat similar to that observed in patients taking combination oral contraceptives.

Since none of the above mechanisms alone seems to be able to account for the relatively high degree of antifertility action of these steroids, it must be assumed that the effects are a result of the combined actions of these drugs: Inhibition of ovulation, alterations of corpus lutein function, cervical mucus changes, sperm penetration inhibition, and endometrial changes all working together to prevent the union of sperm and egg.

Interception

It is known that high doses of estrogen, given in the immediate post-ovulatory period, will prevent implantation in women. Since estrogens do not interfere with the fertilization process itself and will not interrupt an established implantation, they can neither be referred to as contraceptives or abortifacients, when used in this manner. Hence, Morris and Van Wagener (in a recent study at Yale) refer to them as "interceptives."[43] "Interception" can, therefore, be defined as "the process of preventing implantation in a patient after unprotected coitus."

Morris and Van Wagener administered high doses of estrogens in the post-ovulatory period to over 750 women who had had unprotected intercourse at midcycle. Although follow-up on some of these patients (mostly co-eds) was poor, the regimen seemed to be quite effective in lowering pregnancy rates to the 0.3 to 0.03 percent range. While nausea was encountered in one-half of the patients, no serious side effects were noted with the exception of one case of acute pulmonary edema. Compounds which have been used include:

1. Diethylstilbestrol 25 to 50 mg/day—3-5 days

2. Diethylstibestrol diophosphate 50 mg/day—3-5 days

3. Ethinyl estradiol 4 to 5 mg/day—3-5 days

4. Conjugated estrogens 20 to 25 mg/day—3-5 days

The authors remind us that the interceptive effect of estrogen is post-ovulatory rather than

post-coital and hence, it may be necessary (if a patient is in the follicular phase) to wait several days for ovulation to take place before administering the estrogen. The authors measure basal body temperature and wait for a drop to 98°F. The rationale of this method is the subject of considerable controversy. It is true that motile sperm have been noted in cervical mucus five to seven days after intercourse. Therefore, it would theoretically be advantageous to give this interceptive dose during the immediate post-ovulatory period. How to determine rapidly and accurately when this period is present is the point in question.

This method of contraception offers the physician the opportunity of protecting his patients from unwanted pregnancy "after the fact." This is ideal for the prevention of conception after rape. It, therefore, gives him the benefit of offering his patient any counseling needed at that time, allowing him to stress the fact that a certain responsibility is involved in sexual activity. "After the fact" interception also offers the gynecologist the opportunity to evaluate the psychological impact of the recent sexual activity on his patients. (Many of the reported cases involved young, rather naive girls and the Yale physicians seized this opportunity to engage in a mild degree of psychosexual counseling.) If they felt that the psychological impact of the recent coitus was a bad one involving a sense of guilt, fear of pregnancy or venereal disease, worry over a lack of sexual response or self-esteem, the physicians were able to give advice and reassurance which might hopefully avoid a subsequent psychiatric casualty. Even if the impact of the recent coitus were a good one, the authors felt that "showing a patient motile sperm under the microscope in her own cervical mucus is a sobering experience even to the most liberated."[43]

Prostaglandins

Prostaglandins are a class of C_{20} long-chain hydroxy fatty acids which are found in many tissues and are known to have a wide spectrum of biological activity. Separation of two specific biologically active prostaglandins, namely, E_2 and F_2 (alpha) has caused a resurgence in the study of their use. Several conclusions have been drawn which have little bearing on their use in contraception. Although PGE_2 and PGF_2 (alpha) are effective in inducing labor at term, they will not replace synthetic oxytocin at this point in time.

Laboratory Research

Ovulation-suppressing oral contraceptives now in use (estrogen-progesterone pills) function by their actions on the hypothalamus or on higher brain centers. It is known that other pharmacologic agents also inhibit ovulation; drugs such as tranquilizers and morphine derivatives are known to do this. Another possibility involves interference with ovulation through effects on the central nervous system-pituitary axis. There are humoral substances from the brain which regulate pituitary gonadotropin secretion; indeed, the decapeptide which controls production and release of leutinizing hormone has been isolated, described, and synthesized.[44] It may be very possible to use these releasing factors or analogues acting as competitive antagonists as a basis for a new type of fertility control drug.

Another interesting possibility is the creation of antibodies against circulating gonadotropins. Although this is possible, it is the reversibility of this method which appears to have researchers stymied.

Tubal Transport

It is known that zygote which arrives too early from its transit through the ovarian tube finds the endometrium inadequately developed, so the zygote degenerates. The lability of the regulatory mechanism for normal tubal transport of ova provides an attractive basis for controlled interference with fertility. Since transport is affected by estrogen, progesterone, and other hormones this may indeed be the way (in part) in which the IUD and some of "the pills" now work. This concept may open a new road to further contraceptive techniques.

Other Techniques

Other areas which bear mentioning include:

1. Corpus luteum function: interrupting the progestational preparation and maintenance of the endometrium

2. Myometrial stimulation: prostaglandins

3. Suppression of sperm production: the testes like the ovary, can be secondarily suppressed by a procedure which stops gonadotropin secretion (i.e., progestins). However, finding drugs which will do this without causing the unwelcome side effect of inhibiting the secretion of sex hormones, inhibiting libido and potency has thus far failed.[4]

4. Fertilizing capacity of spermatozoa: "capacitation" or the final maturation stage of spermatozoa allowing them to penetrate and fertilize the egg could be inhibited by several drugs.[4] Again, prostaglandins are suggested.

5. Human seminal fluid: the chemical complexity of human seminal fluid suggests that it may act not as a simple transport media, but that seminal fluid may nourish the spermatozoa in a manner which is unknown. Finding seminal fluid functions, and then inhibiting them, offers still another road to contraception.

6. Pheromones[4]: These are volatile substances which, when transferred from one individual to another of the same species generally in minute amounts evoke some behavioral or developmental response in the recipient.

It is assumed that the method of transmission of pheromones is via olfactory sensation since these effects were reversed when anosmia was surgically induced in the same animals, pheromones have been thought to induce and inhibit ovulation in laboratory animals such as rats and monkeys. We are seeking further knowledge of how pheromone function may open new pathways into the now famous brain-hypothalamus-ovary axis, without which ovulation does not occur.

Potential Methods of Fertility Regulation

A list of potential methods of fertility regulation under present investigation for women can be found in Table 4.[4]

Table 4. *Potential Methods of Fertility Regulation for Women*[4]

Method	*Explanation*	*Status*
Once a month anti-ovulant pill	E-P pill with timed release factor	limited clinical evaluation
Once a month anti-ovulant injection	Long-acting steroid esters	clinical investigation
Once a month vaginal ring	Synthetic progestin released from an elastomere	preliminary trials completed
Long-term anti-ovulant injection	Micro crystallized progestin suspension	extensive clinical trials
Long-term anti-ovulant implant	Chronic release of E-P via subcutaneous implant	early trials
Continuous low dose progestin	Pill, skin implant, vaginal ring, injection, skin absorption or IUD	under extensive testing
Long-term leuteotropin injection	Lengthens the post-ovulatory phase to 90 days; hence, fewer ovulations	not yet tried
Corpus leuteum maintenance by injection of LTH releaser	Requires identification and purification of LTH releasing factor	not yet tried
Monthly oral preparations to cause leuteolysis	as above	not yet tried
Once a month contra-progestational pill	Interferes with luteal maintenance of early decidua	not yet tried
Pre-coital progestins	Rapid changes in cervical mucus	not yet tried
Post-coital estrogen	Discussed in paper	limited human trials
Post-coital antizygotic agents	Find compounds which would appear in tubal fluid and be toxic to zygote	not yet tried
Immunization with sperm antigens	Can be done, but cannot yet be recapitulated. If found, could determine sex by isolating Y and antigen	only laboratory investigations
Immunization with steroid binding proteins	Would prevent estrogenic changes in the ovum	not yet tried
Release of premature egg	Could be done by use of an L-H releaser	not yet tried
Reversible tubal occlusion	Self-explanatory	only animal studies

Summary

The field of contraception, including its history, relationships to world population, and reproductive biology, has been discussed. The methods and concomitant problems of modern contraceptive techniques were reviewed and a brief journey was made into the contraceptive medicine of the future.

All of the work described herein by the thousands of research workers and laboratories at great expense of time and money, has been spent in an effort safely to prevent human fertilization. This effort has been directed against a most worthy adversary, for nothing has impressed the authors as much as the tenacious, unyielding, insurmountable desire of the sperm and egg to unite.

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Delayed Deaths Following Stroke

Patients surviving the first few days following a stroke are more likely to die of other causes than from the direct impact of the stroke. These other causes, if recognized early, often can be treated and the long-term survival rate considerably improved, according to a report in the June 11, 1973 issue of JAMA.

Meyer Brown, M.D. and Myron Glassenberg, M.D., of Northwestern University studied the records of 200 patients with stroke, who died and had autopsies. For those surviving as long as seven days, death appeared more frequently due to diseases not related to stroke, such as pneumonia, blood clots in the lungs, and urinary infections.

Although cerebrovascular disease is listed as the third most common cause of death in the United States, there is little information about the actual mechanism of death in patients who have suffered an acute, terminal stroke.

In the study, Drs. Brown and Glassenberg compared data from 100 patients who died within seven days after stroke to those who survived more than seven days. Those in the quick death group most often died of brain injuries due to the stroke. Those in the longer surviving group often died of other causes.

The most important lesson to be learned from our data is that many of the extracranial abnormalities contributing to or causing the death of the person with acute stroke may be preventable or more effectively treated if detected early and dealt with vigorously.

Stroke often affects bladder-function, and patients are equipped with catheters to remove urine. Prolonged catherization and poor urinary antisepsis may be responsible for a good portion of the urinary tract infections that sometimes are fatal to post-stroke patients.

The value of carrying the stroke patient through his immediate stroke period is shown by study of his long-term prognosis. One-fifth of patients with brain clots are functioning eight years later. Fifty per cent of patients with a stroke *not* involving a clot survive at least five years and only 21 per cent of these survivors are unable to look after themselves.

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WRITE FOR LITERATURE AND SAMPLES

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REFER TO PDR

Five infertile females, at various stages of diagnostic workup, participated in a series of nine two-hour weekly discussion sessions. They ventilated their feelings and anxieties and derived satisfaction from being able to share these with others who were experiencing the same phenomena. A situation of involuntary infertility can be a profoundly distressing emotional state.

Use of Group "Rap Sessions" in the Adjunctive Treatment of Five Infertile Females

Sidney A. Wilchins, M.D./Roselle Park*

As a result of changing attitudes toward contraception and changing legal philosophies toward abortion, the number of babies available for adoption has markedly decreased. As a direct result of this, more and more couples with problems of infertility have been seeking medical assistance in an attempt to overcome this difficulty.

Several reports[1,2,3] have shown that medical studies of couples presenting with this problem fail to locate any specific lesions, malfunctions, or abnormalities of either the male or female partner. Yet, conception still does not occur in these so-called perfectly normal physiologic partners. This would seem to indicate two possible method defects. Either the results and sophistication of testing are inadequate and occult abnormalities are not being diagnosed or, as has been suggested in several other articles,[4,5,6] there is an intimate psychic interplay which affects the status of one's fertility. One may also question what stress, anxiety or pressures are created in a couple undergoing an infertility workup? Thus, psychologic stress has been implicated as both causative agent and effect of infertility studies. It appears that the exact role of the psyche in relation to infertility is at best vague and undefined.

With these concepts in mind, five infertile female patients were approached to determine their willingness to participate in a series of "rap sessions" in order to air the problems and pressures they had been subjected to since undertaking their infertility studies. The group was also to determine, if possible, those pressures which existed prior to their presentation for studies and to discuss whether the presence of any of these pressures had in any way been correlated with their attitudes toward their own infertility.

Method

Five patients seen consecutively for infertility study were asked independently of one another if they had any interest in participating in a discussion group with patients with the same problem. All responded affirmatively. Each was at a different stage of the infertility workup, which has been described elsewhere.[7,8] The mates of the five patients were also simultaneously undergoing urologic evaluation.

Patient #1 was a twenty-three year old female, gravida 0, para 0, ab 0, who had been married for two years and was a laboratory technician.

Patient #2 was a twenty-six year old female, gravida 0, para 0, ab 0, who was a secretary. This patient had been married for four years.

Patient #3 was a thirty-four year old female, gravida 0, para 0, ab 0, who was a housewife. She had been married for a period of nine years.

Patient #4 was a twenty-five year old female, gravida 0, para 0, ab 0, school teacher who had been married for three years.

Patient #5 was a twenty-eight year old female, gravida 1, para 1 (stillbirth), ab 0, who three years prior to presenting for infertility workup had delivered a stillborn male infant. In the three years subsequent to the stillbirth, the patient had been unable to conceive.

The sixth member of the group was a reg-

*Dr. Wilchins is Clinical Assistant Professor, Department of Obstetrics and Gynecology, CMDNJ, New Jersey Medical School.

istered nurse with extensive experience in sexual counseling and the seventh member of the group was the physician. While the group size was arbitrarily chosen, it was felt that a larger group would be unwieldy and make in-depth discussion difficult. Two-hour discussions were held weekly and the group itself decided how many sessions would be held.

Results

The following salient points and attitudes which developed from these sessions are listed in the order in which they arose chronologically and do not reflect order of importance.

(1) Four out of the five patients had an obsessive-compulsive personality pattern.

(2) Patients expressed feelings of guilt and/or inadequacy and some felt pressures from a religious point of view in that they were being untrue to their religion by not being reproductive.

(3) Great difficulty related to the regimentation of fertility studies. All patients uniformly voiced dissatisfaction with having to do basal body temperature charts. They stated they were a nuisance and that they interfered with their normal activities in addition to serving as a constant daily reminder of their own feelings of guilt or inadequacy. The relative timing of intercourse to coincide with the period of ovulation also produced feelings of pressure.

(4) One patient felt that she was under pressure by society to fulfill and play a role, that society expected a female to perform as a mother and that, basically, she was living up to society's expectations for herself rather than her own expectations for herself.

(5) All patients stated pressures and anxieties were often taken out on their husbands.

(6) Hostility was expressed toward their husbands from the point of view that the husbands desired children as much as an expression of their masculinity as their desire to be a parent.

(7) The women also felt that the amount of understanding which their husbands expressed toward them was insufficient. They all agreed that it was most difficult for their husbands to sympathize with and understand the pressures which they felt they were going through. Each patient felt that her husband would not be interested or willing to attend a session, mainly because he would consider this as a slur against his image of maleness.

(8) Three of the five patients had pets. The animals were treated as children; patient #3 commented on the fact that in the presence of the pet, they referred to their respective mate as "Mommy" and "Poppy." Patient #5 felt this expressed a very infantile attitude.

(9) All patients felt that they benefited from these sessions. They felt that they understood their reactions to their problems of infertility and understood the pressures to which they were subject as a result of the childless state of their marriages. The overwhelming conclusion was that a deeper insight into their own situations had been cultivated.

Follow-up

Three years have elapsed since the last meeting of the group. In this interval of time:

Patient #1 has had one normal vaginal delivery without complication and has moved out of the area.

Patient #2 has had no conceptions. She has reconciled herself to the fact that she will never be pregnant although medically, tubal reconstructive surgery could be very helpful.

Patient #3 has had one pregnancy which aborted spontaneously at six and a half weeks. She adopted one male infant at birth.

Patient #4 has been lost to follow up as she moved out of the area.

Patient #5 has had one normal male infant by primary Caesarean section for fetal distress and is pregnant with a second child.

Conclusions

From a strictly medical therapeutic point of view, it is impossible to tell what value, if any, sessions of this sort had in promoting an improved fertility status. The main value seems to be psychological and results from provision of an environment for the release of pressures and frustrations which are associated with a status of involuntary infertility. The overwhelming impression left with the nurse and physician involved in these sessions was the great amount of pressure and the marked sense of personal failure which patients experience when they consider themselves to be infertile.

It is recommended that physicians treating infertility consider the establishment of sessions of this sort for their own patients. We observed that these sessions provide a means of ventilation and understanding which in turn seems to provide the patients with an improved sense of well being and security. If only these goals are achieved, the value of groups of this nature is more than vindicated.

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FDA Restriction on Dispensing Methadone for Medical Use Invalid

A regulation issued by the Food and Drug Administration that permitted only approved hospital pharmacies to dispense methadone for medical purposes was beyond the FDA's authority, a federal trial court in the District of Columbia ruled.

Challenging the regulation as being discriminatory in prohibiting virtually all licensed pharmacies from dispensing methadone when prescribed for medical use, a pharmacy association brought an action in federal court. The regulation permitted only approved hospital pharmacies to dispense the drug for analgesic and antitussive purposes. Most community pharmacies were prohibited from dispensing the drug for any purpose.

Originally approved by the FDA as safe for use as an analgesic and antitussive agent, methadone was later approved for investigational new drug status (IND) for use in long-term maintenance of narcotic addicts. Subsequently, the FDA revoked both its investigative status and its "new drug" approval. The agency issued a new regulatory scheme which was the exclusive means of distribution for the drug. The new regulation contained the provision restricting the distribution of methadone to approved hospital pharmacies.

On a hearing of motions for summary judgment by both parties the federal trial court examined the authority of the two federal agencies which exercised control over methadone. The FDA was responsible for passing on the merit of a new drug application, which must be supported by extensive scientific evidence. Among other reasons, the FDA could refuse to approve a new drug application if there was not adequate evidence that the drug was safe for use under the conditions recommended in the labeling. Claiming that the term "safe" included the drug's being safe from possible misuse, the FDA argued that the interpretation was the statutory basis for its restriction on methadone distribution.

Besides being within the jurisdiction of the FDA, methadone is a Schedule II controlled substance. Under the Controlled Substance Act, the U.S. Attorney General is responsible for the registration of any person who manufactures, distributes, or dispenses any controlled substance. Once a controlled drug has been cleared for marketing, the question of permissible distribution of the controlled drug is solely within the jurisdiction of the Justice Department, the federal court said. The Attorney General has no discretion as to whether or not to register a practitioner. If a pharmacist or other practitioner is authorized to dispense drugs under state law, the Attorney General must register him. Congress clearly had authorized all state-licensed pharmacies to dispense controlled drugs on an equal basis with all other approved distributors, the court concluded.

Since the FDA had overstepped the bounds of its authority in limiting the distribution of methadone to approved hospital pharmacies, the federal trial court granted the pharmacy association's summary judgment motion.

American Pharmaceutical Association v. Weinberger, Civil Action No. 1485-73 (D.C., D.C., June 6, 1974)

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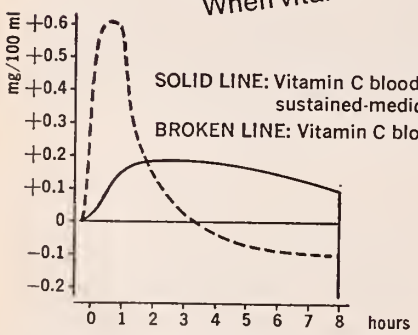

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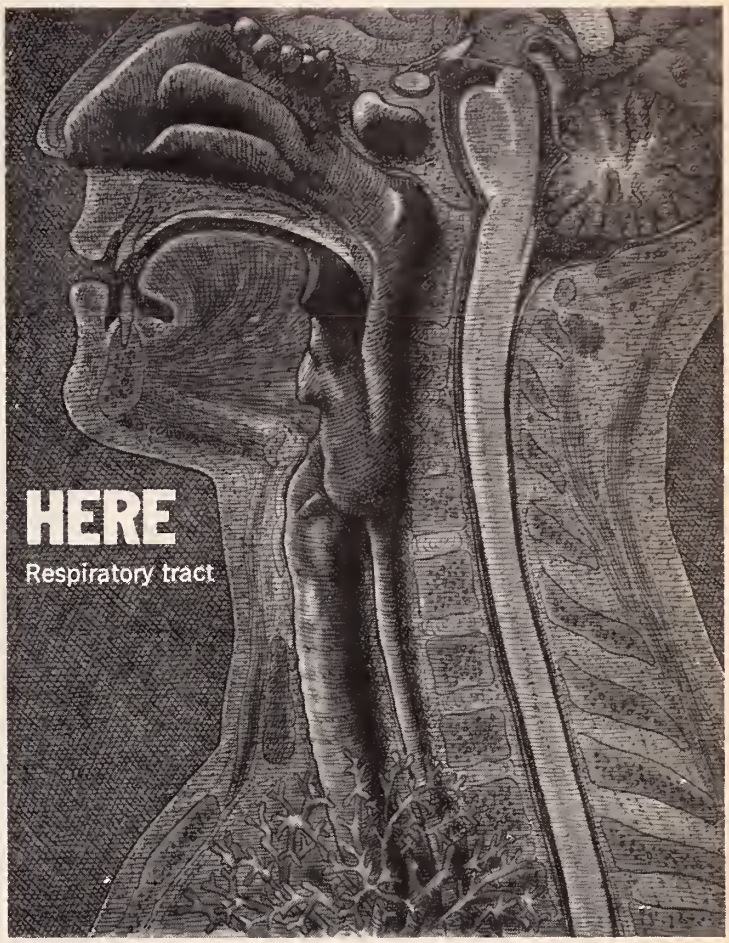

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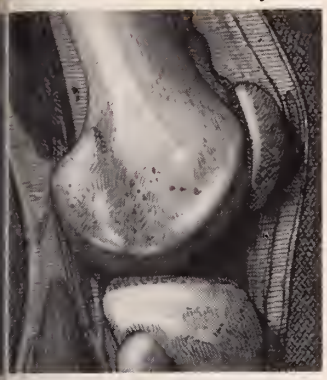

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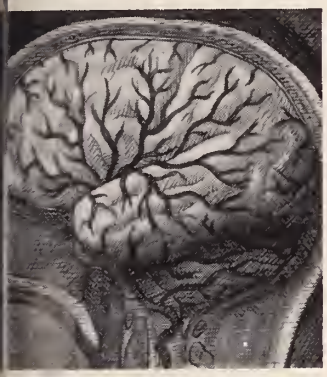

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The Role of the Detail Man

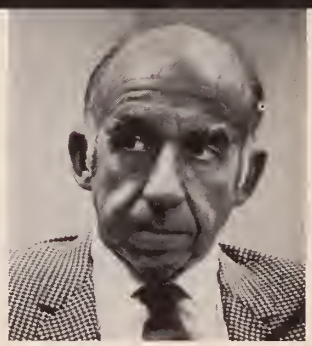
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I very much in favor of the detail r I meet. Most of them are knowle able about the drugs they promo and can be a great help in acqua ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most the men who visit me regularly a they in turn have become aware my particular interests and the n ture of my practice. They, therefore, limit their discussion as mu as possible to the areas of interes to me. Since I usually see the san representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of deali with health problems in this cour there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharma ceutical industry is the type of co tact that people in a medical cent research people, and academic people have and that's in all likeli on a somewhat different level fro that of the practicing physician.

Let me touch on how I perso ally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real edu cational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent film produced by the pharmaceutical industry. When they function in th

He a Source of Information?

Yes, with certain reservations. e average sales representative s a great fund of information out the drug products he is re-onsible for. He is usually able to swer most questions fully and elligently. He can also supply rints of articles that contain a eat deal of information. Here, , I exercise some caution. I usu-y accept most of the statements d opinions that I find in the pers and studies which come m the larger teaching facilities. oes without saying that a physi-n should also rely on other urces for his information on armacology.

ining of Sales Representatives

Ideally, a candidate for the sition as a sales representative a pharmaceutical company uld be a graduate pharmacist o has a questioning mind. I don't nk this is possible in every case, d so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

pacity they are indeed useful; ticularly in the fact that they seminate broadly based educa-nal material and serve not just 'pushers" of their drugs.

Other Side of the Coin

Obviously, the pharmaceuti-companies are not producing all s material as a labor of love—y are in the business of selling ducts for profit. In this regard ambitious and improperly moti-ed sales representative can rt a negative influence on the cticing physician, both by pre-ting a one-sided picture of his duct, and by encouraging the ctitioner to depend too heavily drugs for his total therapy. In se ways, the salesman has often torted objective reality and dermined his potential role as an ucator.

Industry Responsibility

Since the detail man must be information resource as well as epresentative of his particular armaceutical company, he uld be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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CASE REPORT

Obstructive lesions involving the left heart are frequently responsible for neonatal heart failure and have a high mortality. The case here presented is of an infant in whom heart failure developed at three weeks of age. Cardiovascular diagnostic study revealed interrupted aortic arch and large ventricular septal defect. Pulmonary artery banding palliated the infant but recurrent heart failure necessitated referral for definitive surgical repair at three and a half months of age. Successful management of severe cardiovascular malfunctions in neonates requires early recognition of heart failure, prompt and accurate diagnosis, and meticulous postoperative respiratory care.

Interrupted Aortic Arch and Ventricular Septal Defect: Palliation in a Neonate*

O. R. Levine, M.D., J. R. Antillon, M.D., and J. H. Rusoff, M.D./Newark

Congenital cardiovascular lesions resulting in obstruction to left ventricular inflow or outflow contribute significantly to the overall mortality from congenital heart disease during early infancy.[1,2] A wide spectrum of anomalies is represented, to which the term "hypoplastic left heart syndrome" is applied. In its most severe form, severe stenosis or atresia of the mitral or aortic valve is present, the left ventricle is underdeveloped, and clinical manifestations appear during the neonatal period. Milder forms involve coarctation, hypoplasia, or interruption of the aortic arch proximal to the entrance of the ductus arteriosus, with a relatively normally developed left ventricle. The latter group is characterized by a high incidence of associated intracardiac anomalies, particularly ventricular septal defect, and the onset of congestive heart failure during the first weeks of life.[3,4] In contrast to the uniformly poor prognosis of infants with left ventricular hypoplasia, the latter group presents opportunities for a combined medical and surgical approach resulting in the survival of desperately ill infants.

The purpose of this report is to present a case of atresia of the transverse aortic arch associated with a large ventricular septal defect. Congestive heart failure developed during the neonatal period. Diagnostic and therapeutic measures were applied aggressively, culminating in successful palliative banding of the pulmonary artery. Prerequisites for a favorable outcome in such cases are early recognition of congestive heart failure, the avoidance of unnecessary delay in diagnosis and therapy, and optimal postoperative respiratory care.

Case Report

A male child was born on 2/22/74 to a 14-year-old, G1 P0, after an uncomplicated 36 weeks gestation and normal vaginal delivery. The Apgar score was 10 and the birth weight 2100 grams. Intermittent tachypnea, bilateral conjunctivitis, and low-grade fever were noted on the 6th day. A chest roentgenogram showed a large cardiothymic image with patchy infiltrates in both lung fields. Antibiotics were given. Tachypnea

Figure 1A—Chest roentgenogram at 3 weeks of age showing marked cardiomegaly and pulmonary vascular engorgement.

*This work is from the New Jersey Medical School, CMDNJ, where Dr. Levine is Professor of Pediatrics and Director of Pediatric Cardiology. Dr. Antillon is Assistant Professor of Pediatrics, and Dr. Rusoff is Assistant Professor of Radiology and Pediatric Radiologist.

gradually increased, and a cardiac murmur was heard intermittently. At three weeks of age the respiratory rate was 70-80 per minute, inspiratory rales were present, the liver edge was palpable 3 cm below the right costal margin, and the eyelids were puffy. Profuse diaphoresis accompanied feedings. The right femoral pulse was markedly weaker than the right radial. Repeat chest roentgenogram showed marked cardiomegaly and pulmonary vascular engorgement (Figure 1A). A grade 2/6 short, blowing systolic murmur was present at the left sternal border. The electrocardiogram was abnormal, suggesting biventricular enlargement. Blood pressure by flush method was 90 mm Hg in the right arm and 70 mm Hg in the right leg.

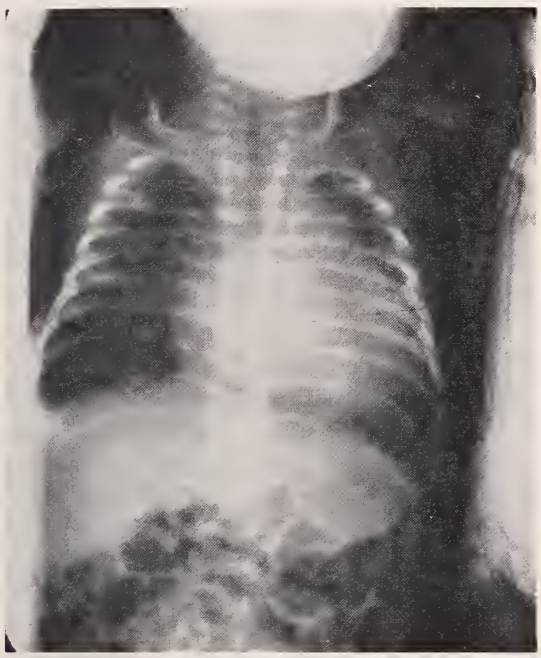
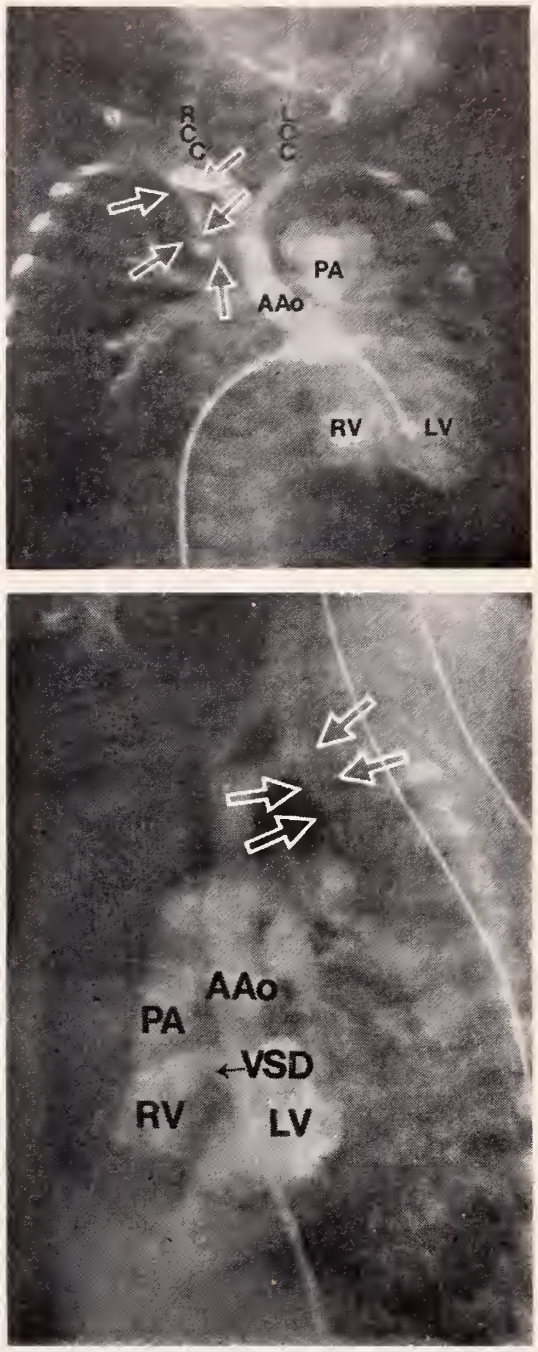


Figure 1B—Chest roentgenogram at 6 weeks of age showing decrease in heart size and in pulmonary vascular engorgement following pulmonary artery banding.

Based on these findings, the diagnosis of coarctation of the aorta with congestive heart failure was made, and digitalization, reduced salt intake, and diuretic therapy were instituted. The infant did not improve significantly on this regimen, and cardiovascular diagnostic study was undertaken (Table 1). The catheterization findings indicated a ventricular septal defect with left-to-right shunting and pulmonary hypertension at systemic level. The catheter traversed a patent ductus arteriosus entering the descending aorta. The oxyhemoglobin saturation in the descending aorta was 95 percent. Selective angiocardiogram (See Figure 2) revealed a normal left ventricle with no evidence of inflow or outflow obstruction. The right ventricle filled immediately via the ventricular septal defect, and the normally arising great arteries were visualized simultaneously. The ascending aorta was less than one-half the caliber of the pulmonary artery, and terminated after giving off the right subclavian and the right and left common carotid arteries. An anomalous arch vessel arose near the origin of the right subclavian artery and coursed posteriorly, to the left and inferiorly, inserting into the descending aorta. The aortic arch was absent between the left common



Figures 2A-B—Angiocardiogram with injection into the left ventricle (LV) at 3½ months of age. A. P-A view. B. Simultaneous lateral view. Contrast material enters a normal-sized LV and traverses a ventricular septal defect (VSD) to enter the right ventricle (RV). The banded pulmonary artery (PA) is approximately twice the caliber of the ascending aorta (AAo). An aberrant vessel arises adjacent to the right common carotid (RCC) and subclavian arteries and courses inferiorly, posteriorly and leftward (arrows) toward the descending aorta. The transverse aortic arch is absent beyond the left carotid (LCC) and there is a significant delay in opacification of the descending aorta.

carotid artery and the entrance of the ductus arteriosus.

Table 1
Catheterization Data, Age Three Weeks

Location	*Oxyhemoglobin Saturation* %	*Pressures Sys*	*Dias*	*Mean*
		mm Hg		
SVC	75			
RA	77	a=5	v=3	2
RV	84	85	7	
PA	88	85	28	58
LA	95	a=11	v=12	5
Desc. Ao	95	45	34	40
Rt. Brachial A.		86	60	(Doppler)

Pulmonary: Systemic Flow Ratio = 2.9
Pulmonary: Systemic Resistance Ratio = 0.3

Table 2
Cathelerization Data, Age Three and a Half Months

Location	*Oxyhemoglobin Saturation* %	*Pressures Sys*	*Dias*	*Mean*
		mm Hg		
SVC	65			
RA	65			5
RV	81	120	9	
PA	77	90	15	47
LA	92			11
LV	92	120	13	
Rt. Femoral A.	79	40	(Doppler)	

Pulmonary: Systemic Flow Ratio = 1.8

The infant was taken on the same day to the operating room, and the pulmonary artery was banded. Postoperatively, the infant was maintained on controlled positive pressure breathing via an indwelling orotracheal tube for 3 days, and was then gradually weaned from the respirator and extubated two days later. Left upper lobe atelectasis was managed with tracheobronchial suctioning. Except for mild persistent tachypnea (respiratory rate 50-50 per minute), the signs of congestive heart failure abated. Chest roentgenograms showed a decrease in heart size and pulmonary vascularity (Figure 1B), and the infant fed well and gained weight steadily. Clinical improvement was maintained until three months of age, when he developed increasing tachypnea, retractions, and fluid retention. Cardiac catheterization was repeated at three and a half months of age (Table 2), showing reduction in left to right ventricular shunting, attributable to the pulmonary artery banding. However, a left ventricular angiocardiogram (Figure 2) showed delay in opacification of the descending aorta, and there was reduction in oxyhemoglobin saturation in this location, suggesting inadequacy of collateral blood flow from ascending to descending aorta. Left ventricular systolic and end-diastolic pressures were elevated, reflecting outflow obstruction and decompensation. Because of the precarious clinical status, and the evidence of inadequate perfusion of the descending aorta, the infant was transferred to another institution for definitive operation. Utilizing deep hypothermia and total circulatory arrest the descending aorta was mobilized and the 2.5 cm interruption corrected by primary anastomosis. The ductus arteriosus was ligated, the ventricular septal defect repaired through a right ventriculotomy, and the pulmonary artery debanded. The postoperative course has been characterized by prolonged, severe pulmonary complications despite excellent cardiac status.

Discussion

The term "adult-type" has been applied to a discrete, isolated aortic coarctation at or just beyond the entrance of the ductus arteriosus, and "infantile-type" to a more diffuse preductal narrowing of the transverse aortic arch.[3,4] Among the groups of infants with coarctation developing congestive heart failure within the first six months of life, it has been convincingly demonstrated that (1) discrete coarctation frequently coexists with varying degrees of tubular hypoplasia of the aortic arch and (2) the incidence of associated major intracardiac anomalies is directly correlated with the presence and severity of arch hypoplasia.[3,4] Also, it is evident that the onset of congestive heart failure during the neonatal period is very likely to signify the presence of arch hypoplasia and of one or more additional hemodynamically significant cardiovascular anomalies.[4]

Isolated hypoplasia or interruption of the aortic arch is rare, and may be compatible with survival to adulthood.[5,6] Absence of associated defects, and the provision of adequate blood flow to the descending aorta via collateral channels, are probably responsible for maintenance of cardiac compensation through infancy and childhood in these cases. Collateralization, by lowering the resistance to left ventricular outflow and providing adequate renal perfusion, may obviate the development of significant hypertension in the proximal aorta, and thus help to avoid overloading of the left ventricle. Although a patent ductus arteriosus may be demonstrated in most cases of hypoplastic or interrupted arch, it is frequently contracted and not the site of significant shunting.[4]

In the case presented here, cardiovascular diagnostic study by catheter passage established the presence of a patent ductus arteriosus, and of a large left-to-right shunt via a ventricular septal defect. Left ventricular systolic pressure was not markedly elevated, and the high oxy-hemoglobin saturation in the descending aorta suggested that it was adequately perfused via the anomalous vessel arising

adjacent to the right subclavian artery. Also, a significant hemodynamic role of the ductus was excluded by the failure to demonstrate shunting from the high-pressure pulmonary artery into the lower-pressure descending aorta. Thus it was concluded that the major factor responsible for progressively severe heart failure was the large ventricular shunt, justifying pulmonary artery banding as a palliative procedure.

Recent reports lend strong support to surgical intervention in infants with aortic coarctation developing congestive heart failure during infancy.[4,7] A variety of palliative and corrective procedures has been employed, depending upon the particular anomalies present and the surgical capabilities available. The aims of surgical therapy are: (1) the establishment of adequate perfusion of the descending aorta from the ascending aorta, either by direct anastomosis or by bridging the gap using a subclavian artery or a synthetic tubular graft, and (2) the palliation or correction of associated lesions. Correction of ventricular septal defect and of other major anomalies has been accomplished in neonates using deep hypothermia[8,9] and avoids the hazards and limitations of early palliative procedures. These reports, and the present case, illustrate the feasibility of definitive correction of complex cardiovascular anomalies in young infants. However, until the safety of deep hypothermia and prolonged circulatory arrest have been established these techniques should be applied only in those situations unmanageable by more conservative methods.[10]

The present case highlights several aspects of the management of infants with life-threatening congenital heart disease: (1) Early recognition of congestive heart failure is mandatory, and involves the appreciation and proper interpretation of tachypnea, retractions, cardiomegaly and hepatomegaly, with or without an easily audible cardiac murmur; (2) The decision as to the advisability of a period of observation on medical management alone, and the timing of cardiovascular diagnostic study, is one which requires expertise, since rapid progression and sudden death frequently characterize the course of serious cardiac anomalies in neonates. It is therefore recommended that a pediatric cardiologist be consulted from the outset; (3) The cardiovascular study should provide a complete and accurate definition of the morphological and physiological aspects of the anomaly. In order to minimize the duration and hazards of the procedure, it should be done by personnel experienced in the study of young infants, with appropriate attention to body temperature, acid-base status, blood loss, and fluid and electrolyte balance. Frequently this requires early transfer of the critically-ill neonate to a regional center in which these services are available at all times; (4) Successful perioperative management of these infants requires, in addition to skillful surgery, optimal overall pediatric intensive care with particular attention to postoperative respiratory management. Mechanical respiratory support and meticulous tracheobronchial toilet are almost always necessary postoperatively, and are generally available on a round-the-clock basis only in referral centers specializing in the care of these problems.

Adherence to these principles of management will result in a markedly improved salvage rate among infants with serious congenital heart disease.

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100 Bergen Street

Ampicillin Resistant Strains of Hemophilus Influenzae Type B

Strains of Hemophilus influenzae Type B highly resistant *in vitro* to ampicillin have been reported from several widely separated locations in the United States since December 1973. These strains were isolated from children with meningitis and the clinical course corroborated the *in vitro* susceptibility results. Until the importance of these resistant strains can be ascertained, hospital laboratories are urged to test clinical isolates of Hemophilus influenzae Type B for susceptibility to ampicillin, and physicians must reconsider the treatment of patients with severe disease due to this organism.

Ampicillin disc sensitivity tests of Hemophilus influenzae isolates are satisfactory for screening purposes, but strains that are of equivocal sensitivity or are resistant should also be tested by a quantitative method, such as the tube or agar dilution techniques. The appropriate methods for antibiotic susceptibility tests were reviewed recently in a weekly report of the Center for Disease Control. Confirmation of resistant strains is strongly suggested. These isolates may be forwarded, via the State Public Health Laboratory to the Center for Disease Control.

In areas where resistant strains have been recognized, initial therapy of children with documented or suspected severe infection due to H. influenzae type B, such as sepsis, meningitis, epiglottitis, arthritis, or cellulitis, should include an antimicrobial agent of known efficacy. Initial administration of ampicillin and chloramphenicol or penicillin G and chloramphenicol would seem appropriate at this time. The antimicrobial regimen should be reevaluated when the results of the bacterial isolation studies and antimicrobial sensitivity tests are available. Therapy should be continued with the single most appropriate agent.

In those areas where laboratory surveillance of H. influenzae strains has not documented ampicillin resistance, it is reasonable to continue to employ ampicillin alone for acute meningitis and other severe infections.

Where laboratory data are not presently available, ampicillin may still be used for initial therapy. The patient's course should be closely monitored and another active drug should be substituted if the clinical and bacteriologic response is unsatisfactory at 24 to 48 hours. Children who have received ampicillin immediately before the acute illness must be observed with particular caution. Hospital laboratories should be urged to use the antimicrobial sensitivity tests recommended by the Center for Disease Control for all strains of H. influenzae Type B.

Although ampicillin resistant H. influenzae Type B appears to be a new phenomenon, the prevalence of these strains is uncertain. The current recommendations are based on information available at this time, but will undoubtedly require revision as new data become available. Physicians must be alert for alterations in the pattern of antimicrobial sensitivity of strains of H. influenzae Type B in their community. The Center for Disease Control will publish reports of cases of interest through the weekly Morbidity and Mortality Reports.

Statement from the American Academy of Pediatrics, Committee on Infectious Diseases, August 1974.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

October 20, 1974

A regular meeting of the Board of Trustees was held on October 20, 1974, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

NJHA and MSNJ Executive Committees . . . Received as informative, notice that the New Jersey Hospital Association has agreed to hold monthly meetings of its Executive Committee with MSNJ's Executive Committee; one other member of the Board of Trustees of each organization will be invited to attend, on a rotating basis.

Health Care Facility Defined . . . Received as informative, notice that Commissioner Finley (Department of Health) has published a proposed regulation to bring New Jersey law into conformity with the federal law—Section 1122 of the Social Security Act, which defines the term "health care facility." The Executive Director is of the opinion that the practicing physician will not be adversely affected if this regulation is enacted; further study will be made and MSNJ's position statement will be presented on November 20.

Bicentennial Celebration . . . Approved the following recommendation and directed that it be referred to the Committee on Finance and Budget for implementation:

That $1,000 be allocated to the Committee on National Bicentennial Celebration for production of an exhibit on the history of medicine in New Jersey.

Press at House of Delegates' Sessions . . . Concurred in the following recommendation of the Council on Public Relations (originally proposed by the Committee on Annual Meeting and referred to the Council by the Board) and directed that it be presented to the House of Delegates for concurrence at the opening session:

That members of the press, displaying official badges, be admitted to the sessions of the House of Delegates.

Public Relations Continuing Projects . . . Approved the following continuing projects for the Council on Public Relations:

1. Publication and distribution of (a) *Junior Health Hints* to schools and public libraries, (b) *Membership Newsletter*, and (c) *Periodic Newsletter* to cooperating agencies/individuals, as required.

2. Preparation and publication of special news releases as required in furtherance of the Society's activities, including (a) the eye health screening program, (b) the annual meeting, (c) child safety week, and (d) selected official programs.

3. Press releases and information center at annual meeting.

4. Bestowal of Golden Merit Award

5. Orientation programs for new members under sponsorship of component societies.

6. Encouragement of statewide emergency medical care coverage.

7. Future Physicians' Clubs

8. Voluntary blood donations.

9. Radio broadcasts under auspices of component medical societies.

10. Medical TV programs

11. Diabetes Detection Week

12. Placement Service

13. Physician awards for community services: A. H. Robins Award and Sheen Award.

Distinguished Physicians' Fund . . . Approved the following recommendations from the Committee on Medical Student Loan:

1. That, rather than establishing separate funds, one fund within the Medical Student Loan Fund be designated as the "Distinguished Physicians' Fund," with an appropriate plaque listing names of such physicians; contributions would be directed to the Fund in the name of the individual doctor.

2. That the above matter be referred to the Council on Public Relations for implementation and solicita-

tion of contributions to establish this Fund, as well as to publicize the Medical Student Loan Fund in order to increase overall contributions.

Physicians' Relief Fund . . . Approved the following recommendations as amended by the Board from the Committee on Physicians' Relief Fund:

1. That the Chairman of the Committee on Physicians' Relief Fund be empowered to decide on an initial grant (up to $1,000) to be made to the applicant in form of a loan, for which determination on its repayment will depend on the Committee's review of the completed application from the component society.

2. That the Committee on Finance and Budget be called upon in the Spring of each year to review the financial condition of the Physicians' Relief Fund and, if necessary, include in the per capita assessment a levy sufficient to maintain a working capital in excess of $35,000 principal.

New Jersey Foundation for Health Care Evaluation . . . Noted that the recommendation adopted by the 1974 House of Delegates to provide a $10 per capita assessment to the New Jersey Foundation for Health Care Evaluation contained no conditions or restriction on this special assessment for the year 1975.

Annual Meeting—1975 . . . Noted that the 209th Annual Meeting, MSNJ, will be held May 31-June 3 at Cherry Hill and approved the following recommendations, as amended by the Board:

1. That a block of rooms be reserved at the Hyatt House (convention headquarters hotel) for Officers, Trustees, members of the Committee on Annual Meeting, members of the House of Delegates, and MSNJ staff.

2. That the 1975 Officers' Dinner be held on Saturday evening and that the list of invited guests follow that of previous years—Officers, Trustees, Fellows, Judicial Councilors, AMA Delegates, Ex-Trustees who had served three-full terms, *Speaker and Vice Speaker of the House of Delegates*, invited guests, and their wives. (Italics indicate Board amendment.)

3. That the Technical Exhibitors' Reception-Buffet Dinner be held during the 1975 Annual Meeting and that it be scheduled for Saturday evening, May 31;

That tickets be made available for those members of MSNJ who wish to purchase them (at a price to be determined at a later date); and

That the technical exhibitors, medical assistants, members of the Committee on Annual Meeting and the Subcommittee on Scientific Exhibits, and members of MSNJ's staff receive complimentary tickets.

4. That the Inaugural Reception honoring the President-Elect be held on Sunday evening, June 1, at 6:30 p.m., and that the Society assume responsibility for expenses incurred up to $2,500, as in the past; and

That unless the President-Elect and his component society be opposed to the idea, the dinner annually sponsored by the President-Elect's component society not be scheduled.

5. That the annual dinner-dance honoring the President be scheduled on Monday evening, June 2, 1975, in the banquet hall of the headquarters' hotel.

6. That the Committee on Annual Meeting be authorized to ascertain what entertainment would be available for the annual dinner-dance.

7. That the First Governor's Conference on Unresolved Questions Affecting the Delivery of Health Care be scheduled for Saturday, May 31, 1975, from 9:30 a.m. to 12:30 p.m.

8. That the honoraria presented to guest-speakers be increased from $100 to $150.

9. That the April issue of *The Journal* be retained as the Convention issue, and that a rerun of the convention highlights be carried in the May issue.

10. That, to insure maximum traffic flow through the exhibits, the escalators to the upper floors be in use only during sessions of the House of Delegates.

11. That individuals and organizations specified by the Committee on Scientific Exhibits receive applications to present scientific exhibits at the 1975 annual meeting.

12. That individuals and organizations specified by the Committee on Scientific Exhibits receive applications to present informational exhibits at the 1975 annual meeting, and that the usual charge of $150 per ten feet be waived for exhibits presented by the Academy of Medicine JEMPAC, Widows and Orphans, and committees of MSNJ.

13. That the application for scientific exhibits also be printed in the January issue of *The Journal*.

14. That in 1975, there be a 1st and 2nd award plaque presented to New Jersey exhibitors; 1st and 2nd award plaques presented to out-of-state exhibitors; a special award plaque presented by the Subcommittee on Scientific Exhibits to a New Jersey exhibitor; and four or five honorable mention certificates presented to New Jersey and/or out-of-state exhibitors.

Committee on Long Range Planning and Development . . . Concurred in the action of the Executive Committee in approving the following recommendations from the Committee on Long Range Planning and Development:

1. That the Board of Trustees approve the method of implementation recommended by the Committee on Long Range Planning and Development in order to accomplish the intent of objective #1. (See below)

Objective 1: To expand and improve MSNJ's ability to sense the needs of the membership, and to expand MSNJ's base of program support by more closely involving county and specialty societies in the develop-

ment and implementation of MSNJ's programs and goals.

Methods of Implementation:

(a) That component societies establish a responsible executive staff position, to be filled by a physician or layman, whose duty it would be to represent the county at all relevant, pertinent, or required State Society meetings to garner information and to disseminate that information at county level in order to elucidate important issues in the hope that a more enlightened membership may be developed. (It is recognized that some counties may have to be regionalized, since they may not be able to underwrite the cost entailed.)

(b) That the quarterly meetings for component society executives held at MSNJ be expanded to include staff personnel of specialty societies and the Academy of Medicine of New Jersey, as well as the President of MSNJ and the Chairman of MSNJ's Board of Trustees.

(c) That component societies encourage participation and representation of local hospital medical staffs in their society functions.

2. That the Board of Trustees call the matter to the attention of the component societies they represent, with the request that the counties place the topic on the agenda of their monthly meetings.

Board of Trustees' Vacancy . . . Elected Augustus L. Baker, Jr., M.D. of Morris County as Trustee from the 1st Judicial District to fill the vacancy created by the resignation of Francis J. Benz, M.D., reported last month.

House of Delegates—Special Session . . . Directed, as a consequence of petitions from four component societies requesting reconsideration of Resolution #29 (membership in AMA as condition for continued membership in MSNJ), adopted by the 1974 House of Delegates, that a Special Session of the House of Delegates be scheduled for Sunday, December 8, 1974 at 10 a.m. at Rutgers Medical School, Piscataway—Main Auditorium of Building "C."

. . . Voted to submit a resolution at the upcoming Special Session of the House of Delegates reaffirming its support of Resolution #29 and setting a specific date for implementation.

. . . Authorized the Executive Director to engage the services of an outside attorney to develop an opinion on the issue of whether a Bylaw amendment would be required to implement Resolution #29.

Dissatisfaction with MSNJ's Official Policies—Ocean County . . . Concurred in the Executive Director's reply to the Ocean County Medical Society expressing concern with official positions taken by MSNJ on such issues as PSRO, mandatory AMA dues, defining laboratory fees, and matters concerning billing, and directed that the Ocean County Medical Society be informed of the Board's approval of the reply made by Mr. Maressa.

Unlicensed Physicians in Hospitals . . . Reaffirmed its opposition to the use of unlicensed physicians except when serving in approved educational programs and directed that the Hudson County Medical Society be notified that its request had been denied.

Note: The above was in consequence of a request from the Hudson County Medical Society to have MSNJ introduce appropriate legislation recommending that the State of New Jersey adopt a law, similar to that adopted in New York, which allows limited practice, for a two-year period, under supervision of a licensed physician only in a public, voluntary, or proprietary hospital.

Advisory Committee for Minimum Requirements for Health Institutional Long Range Plans . . . Authorized the President and the Chairman of the Board to select MSNJ's representative to the above-named Committee. (Matthew E. Boylan, M.D. was subsequently appointed to serve.)

New Jersey Hospital Association . . . Received as informative the following report of actions of the NJHA Board of Trustees' from MSNJ's liaison to the New Jersey Hospital Association (Dr. Madara):

1. Referred back to the Council on Hospital Reimbursement the Department of Health Grant Application for money to evaluate quality of care, with the hope that it not be endorsed; it was suggested that this matter be on the agenda of the next joint meeting of the Executive Committees of NJHA and MSNJ.

2. Agreed to have a joint meeting with MSNJ's Council on Legislation to work out an agreement on A-1257 (substitution of generic-named drug for trade-named product).

3. Reaffirmed opposition to S-753 (bioanalytical laboratories).

4. Referred to Executive Committee recommendation that NJHA meet with leaders in the legislature toward amending "certificate of need" legislation.

5. Agreed not to endorse draft legislation establishing the classification of physician's assistant.

6. Agreed not to participate in survey of abortion statistics by the Center for Family Planning Program Development.

7. Agreed to work with MSNJ in seeking solution to the unlicensed physician problem.

8. Agreed to work with MSNJ in rewording the position paper on "free-standing ambulatory care facilities."

American Hospital Association . . . Received with commendation the following report from Dr. John S. Madara, physician delegate to the October meeting of the Regional Advisory Board of the AHA, the principal topic of which was proposed changes in the guidelines for implementation of certificates of need for health care facilities and services:

The original language of the "Scope of Coverage" section was amended to read (deleted language in parenthesis, new language in italics):

"The Certification-of-Need program should cover all (providers) *health facilities,* including but not necessarily limited to, the following: hospitals, extended care institutions, skilled nursing facilities, outpatient care facilities, home care institutional programs, health maintenance organizations, health care corporations, foundation research facilities, and outpatient surgical and single procedure facilities, *diagnostic or treatment centers substantially similar to health care services normally offered by a health care provider which is subject to Certification of Need.*

"The process should not include practitioners of the healing arts singly or in groups in the conduct of their profession or vocation independently of a health care (provider) *facility.*"

The Regional Advisory Board voted to recommend these amended "guidelines" to the Board of Trustees of AHA for adoption. (There were two negative votes—Dr. Madara and a Trustee.)

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Communicable Disease Control Program of the New Jersey State Department of Health during August 1974:

	1974 October	1973 October
Asceptic meningitis	12	32
Primary encephalitis	3	3
Hepatitis: Total	205	146
Infectious	103	69
Serum	39	28
Unspecified	63	49
Meningococcal meningitis	1	2
Mumps	23	23
German measles	6	5
Measles	58	21
Salmonella	77	120
Shigella	9	34
Tuberculosis	74	
Syphilis: Total	72	
Primary	31	
Secondary	41	
Gonorrhea	1478	

Note: Gonorrhea, syphilis and tuberculosis are figures for the previous month.

An impressive number of national organizations and their New Jersey affiliates cooperated with the Center for Disease Control in sponsoring Immunization Action Month, October, 1974. While many areas of the country focused on health education efforts aimed at stimulating awareness in dealing with immunization rates, New Jersey observed the month with several serious outbreaks of measles, most of which were among adolescents and young adults. A total of 58 cases of measles were reported during the month. Outbreak control programs were conducted at a regional high school (Somerset County) and at a State College.

Measles

An indepth study by the Vaccination Assistance Program Staff was conducted in two Bergen County communities, where a large outbreak of measles occurred last spring among students in secondary schools. The study reveals that prior to the outbreak, the local junior and senior high school population had immunity levels between 90 and 94 percent as confirmed by either a history of disease or live virus vaccine administration. The implication is that measles can spread rapidly even in a highly immune population. The doctrine of "herd immunity" (which holds that the minority of susceptible persons within a population can be protected against disease by maintaining an immunity threshold of more than 85 percent) may not apply for measles. The disease, once introduced, can "seek out" almost every susceptible individual.

We urge persons susceptible to measles to obtain the vaccine. A reimmunization is indicated for any individual who has not had either the disease or live virus vaccine. This would include children immunized at less than one year of age and individuals who received the killed virus vaccine. Private physicians, local health departments, and school health officials, having access to information which defines susceptibles, should promptly recommend and follow through with immunization.

We also urge private physicians and school officials to report suspected cases of measles promptly to their local health department or to the State Department of Health (609) 292-7300. Prompt reporting can initiate outbreak control programs and thereby limit the spread of disease.

Therapeutic Drug Information Center

The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center of the New Jersey Regional Medical Program and the Brookdale Inter-regional Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, conjointly compile the information contained in this column each month. The New Jersey component is located at the Valley Hospital in Ridgewood. The Center serves as a source of intelligence on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions, and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor of Pharmacy and Director of Drug Information, Brooklyn College of Pharmacy, is Project Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College is pharmacologist consultant. The service is free, available Monday through Friday from 9 a.m. to 5 p.m.—telephone (201) 445-4900, extension 132. Following are questions and answers handled by the Center recently.

1. Do you have any information comparing the commercially available cephalosporins?

Seven different cephalosporin antibiotics are now commercially available. The following chart summarizes important data concerning these drugs.

Generic Name	Trade Name (s)	Route	Daily Dose	Serum T ½ (Hours) (a)	Route (s) of Elimination	Advantages	Disadvantages	Cost to Pharmacist for 1 Day's Therapy (b)
Cephalexin	Keflex®	po	250 mg to 1 Gm qid (1 to 4 Gm daily)	0.9 ± 0.02 (Low protein binding)	Kidney	High urine levels; acid stable; more resistant to staphylococcal penicillinase than is cephaloridine	Possible nephrotoxicity	$1.20-$4.65
Cephaloglycin	Kafocin®	po	250 mg to 500 mg qid (1 to 2 Gm daily)	unavailable	Kidney, liver	High urine levels; acid stable	Only useful for urinary tract infections	$1.26-$2.52

(a) Serum T ½ is the time for 50 percent of a drug to be eliminated.

(b) Prices based on 1974 Blue Book. (Siegelman, S.: *American Druggist Blue Book*, 44th Edition, The Hearst Corporation, New York, 1974.)

Cephaloridine	Loridine®	IM, IV	500 mg to 1 Gm qid (1 to 4 Gm daily)	1.5	Kidney	It is more potent and yields higher and more sustained serum levels than cephalothin	Nephrotoxicity; false positive direct Coombs' has been reported; (c) Furosemide (and perhaps also ethacrynic acid) may enhance the nephrotoxicity of cephaloridine (d)	$7.80-$14.30
Cephalothin (e)	Keflin®	IM, IV*	500 mg to 2 Gm q 4-6 hrs (2 to 12 Gm daily)	0.47 ± 0.13 (Intermediate protein binding)	Kidney, liver	Few toxic side effects; high serum levels can be obtained	Possible nephrotoxicity; severe pain on IM administration; thrombophlebitis is a rather common complication when large doses are given IV	$5.60-$33.00
Cephapirin	Cefadyl®	IM, IV	500 mg to 2 Gm q 4-6 hrs (2 to 12 Gm daily)	0.62 ± 0.2 (Intermediate protein binding)	Kidney, liver	May be lower incidence of phlebitis than with Cephalothin therapy; nephrotoxicity not reported to date	Unknown at this time but probably similar to other cephalosporins	$5.00-$29.40
Cefazolin (f)	Kefzol® Ancef®	IM*, IV	250 mg to 1 Gm q 6 to 8 hr (0.75 to 4 Gm daily	1.8 ± 0.2 (very high protein binding)	Kidney	Peak serum concentration and duration of action is greater than for Cephalothin or Cephaloridine	Possible nephrotoxicity	$3.90-$20.60
Cephradine	Velosef®	po (as of this writing, no parenteral form is commercially available)	250 mg to 500 mg qid (1 to 2 Gm	0.7 (Intermediate protein binding)	Kidney other (?)	Rapidly absorbed when given orally; acid stable high urine levels obtained	Unknown at this time, but probably similar to other cephalosporins	$1.35-$2.70

*Preferred

(c) As cephaloridine has produced a false positive direct Coombs' test, it should be recognized that a patient receiving any cephalosporin antibiotic may develop a false positive direct Coombs.

(d) Furosemide and perhaps ethacrynic acid may enhance the nephrotoxicity of any cephalosporin drug that is nephrotoxic.

(e) and (f) *The Medical Letter* states that when a parenteral cephalosporin is indicated, either cephalothin (Keflin®) or cefazolin (Ancef®; Kefzol®) is preferred; cefazolin is less painful on intramuscular injection. (Anon: Cephapirin. *The Medical Letter* 16:53-54 June 21, 1974.)

2. I understand that there is a new treatment for heartburn utilizing bethanechol. Have you heard about it?

Incompetence of the pressure barrier at the gastroesophageal junction is a major factor in the pathophysiology of gastroesophageal reflux and heartburn. Heartburn can be caused by inadequate constriction of the low esophageal sphincter. The pressure in the stomach increases and the weak sphincter muscle allows the pressure to produce a gastroesophageal reflux. This causes the pain associated with heartburn.

It has been known that subcutaneous injection of the cholinergic agent, bethanechol (Urecholine; Myocholine) increases lower esophageal sphincter (LES) pressure in both normal subject and in patients with gastroesophageal reflux.[1] Recently, oral bethanechol also has been shown to produce a sustained rise in lower esophageal sphincter pressure. Farrell[2], *et al.*, studied its effects on 20 patients with chronic heartburn who had evidence of lower sphincter incompetence. In a randomized double-blind crossover study, each patient received either 25 mg bethanechol or placebo four times a day for two months; after a two-month rest period the opposite treatment (drug or placebo) was given for two months. The patients' symptoms were evaluated each month of the study. Antacid, taken as desired, was quantitated monthly. The results showed significant improvement in heartburn symptoms and decreased antacid use during bethanechol therapy.

The marked stimulatory effects of oral bethanechol on the lower esophageal sphincter and the apparent low side effects at the dosage utilized suggests that this agent may be a welcome addition to therapy of refractory heartburn, and it might be a logical approach to the treatment of an age-old problem.

References

[1] Castell D O: Heartburn: New insights into our age-old problem. *Drug Ther* 2:78-80 (Oct) 1972.

[2] Farrell R L, *et al*: Cholinergic therapy of chronic heartburn, a controlled trial. *Ann Intern Med* 8:573-576 (May) 1974.

3. What is the latest recommended treatment of gonorrhea in adults?

The latest recommended treatment is as follows:[1]

Uncomplicated Gonococcal Infections in Men and Women

Drug Regimen of Choice—Aqueous procaine penicillin G (APPG) 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with one gm of probenecid (Benemid®) by mouth just before the injections.

Alternative Regimens—

(a) Patients in whom oral therapy is preferred: Ampicillin 3.5 gm by mouth, together with one probenecid by mouth administered at the same time. There is evidence that this regimen may be slightly less effective than the recommended APPG regimen.

(b) Patients who are allergic to the penicillins or probenecid (i.e. allergy to penicillin, ampicillin, probenecid, or previous anaphylactic reaction):

(1) Tetracycline hydrochloride, 1.5 gm initially by mouth, followed by 0.5 gm by mouth 4 times per day for 4 days (total dosage 9.5 gm). Other tetracyclines are not more effective than tetracycline hydrochloride. All tetracyclines are ineffective as single-dose therapy.

(2) Spectinomycin hydrochloride, 2 gm intramuscularly in one injection.

Treatment Failures—Most recurrent infection after treatment with the recommended schedules is due to reinfection. True treatment failure after therapy with penicillin, ampicillin, or tetracycline should be treated with two gm of spectinomycin intramuscularly.

Postgonococcal Urethritis—Tetracycline 0.5 gm 4 times a day by mouth, for at least 7 days.

Pharyngeal Infection—Pharyngeal gonococcal infections may be more difficult to treat than anogenital gonorrhea. Post-treatment cultures are essential follow-up for pharyngeal infection. The schedules of ampicillin and spectinomycin recommended for anogenital gonorrhea are ineffective in pharyngeal gonorrhea. Patients whose infection is not eradicated after treatment with 4.8 million units of APPG plus 1 gm of probenecid may be treated with 9.5 gm of tetracycline in the dosage schedule outlined above (alternative regimens).

Syphilis—All patients with gonorrhea should have a serologic test for syphilis at the time of diagnosis. Seronegative patients without clinical signs of syphilis who are receiving the recommended parenteral penicillin schedule need not have follow-up serologic tests for syphilis. Patients treated with ampicillin, spectinomycin, or tetracycline should have a follow-up serologic test after three months to detect inadequately treated syphilis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Not Recommended—Although long-acting forms of penicillin (such as benzathine penicillin G) are effective in syphilotherapy, they have *no* place in the treatment of gonorrhea. Oral penicillin preparations such as penicillin V are not recommended for the treatment of gonococcal infection.

In the above treatment, physicians are cautioned to use no less than the recommended dosage of antibiotics. Also, when children are postpubertal and/or over 100 pounds, he or she should be treated with dosage regimens as defined above for adults.

Reference

[1] Anon.: Gonorrhea—CDC recommended treatment schedules, 1974. *Mobidity and Mortality* 23:341-342 (Oct 5) 1974.

4. Is an atropine-containing drug always contraindicated in patients with glaucoma?

Almost any drug with anticholinergic activity[a] has a warning included in its labeling to the effect that it should not be used by patients with glaucoma.

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[a] The main groups of drugs bearing a warning for use in glaucoma include: (1) antispasmodics, *e.g.*, atropine, propantheline; (2) phenothiazine derivatives, *e.g.*, chlorpromazine, trifluoperazine; (3) tricyclic antidepressants, *e.g.*, amitryptyline, desipramine; (4) monoamine oxidase inhibitors, *e.g.*, isocarboxazid, tranylcypromine; (5) miscellaneous agents, *e.g.*, antihistamines, decongestants, adrenal corticosteroids.

Glaucoma can be conveniently classified into primary, secondary, and congenital types. Primary glaucoma can be further divided into simple open angle glaucoma, also known as wide angle, (refers to angle between the iris and corneoscleral recess) and angle closure glaucoma which is also called narrow angle glaucoma. Open angle glaucoma is the most commonly occurring form and accounts for about 90 percent of the cases of glaucoma diagnosed.

Less than five percent of the glaucomas are of the narrow angle type.[1] In this type of glaucoma the angle made between the iris and corneoscleral recess becomes critical. As this angle closes off, the intraocular pressure rises rapidly and the classical symptoms of pain, redness, and blurred vision result. Angle closure (narrow angle) may be precipitated by atropine, cycloplegic, or mydriatic agents, or by any of the anticholinergic drugs which dilate the pupil and crowd the already narrow angle. This is probably the form of glaucoma for which the original warnings were placed on the drug products.[2] Therefore, it is necessary that these patients be monitored by an ophthalmologist when placed on anticholinergic drugs during initial therapy and warned against discontinuing his miotic for any reason.

The open angle glaucoma patient is not in the same danger since drug-induced elevations of pressure are reversible even if several pilocarpine instillations are missed.[3]

In conclusion, in patients under treatment for open angle glaucoma, it is probable that in most instances, the potential adverse effects of systemically administered anticholinergic drugs would be completely counteracted by the drugs being used for the treatment of glaucoma.[4] Therefore, the use of systemic anticholinergic drugs is *not necessarily* contraindicated in patients with this form of glaucoma.

References

[1] Tong T G and Ignoffo R J: Glaucoma. *J Am Pharm Assoc* 12:522-524 (Oct) 1972.

[2] Frank M G: The drug-induced glaucomas. *J Med Soc NJ* 71:470-472 (June) 1974.

[3] Willetts G S and Hopkins D J: Systemic therapeutic agents and glaucoma. *Practitioner* 209:27-34 (July) 1972.

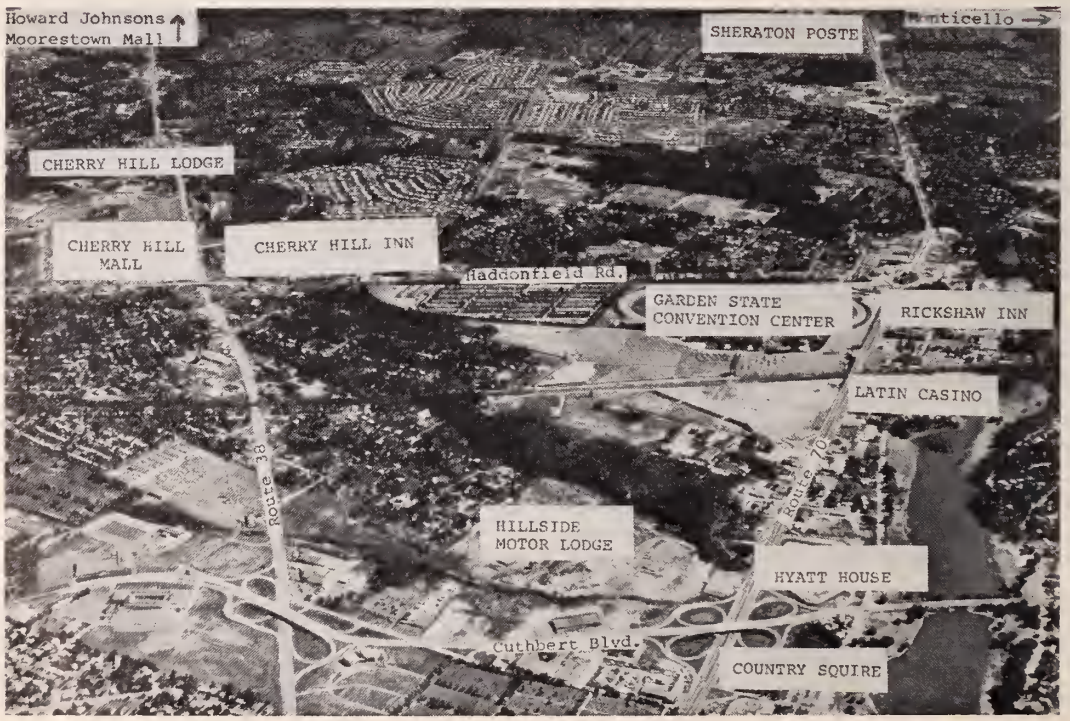
[4] Grant W M: Ocular complications of drugs, glaucoma. *JAMA*, 207: 2089-2091 (Mar 17) 1969.

209th Annual Meeting

May 31 – June 3

Garden State Convention Center – Cherry Hill

Aerial View of Site



PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

CARDIOLOGY—George E. Berk, M.D., Ridder Apts. 4-5, Apt. 3-D, Valley Road, Manhasset, N.Y. 11030. Cornell 1968. Board eligible. Group, institution, cardiac catheterization opportunity. Available July 1975.

Erich Schneider, M.D., 6632 Aintree Park Dr., Cleveland 44143. Porto Alegre (Brazil) 1964. Board eligible. Group or partnership. Available July 1975.

INTERNAL MEDICINE—John V. Mendola, M.D., 289 Kerrigan Boulevard, Newark 07106. Hahnemann 1972. Board eligible. Small group, partnership, or solo. Available June 1975.

P. Govindarajan, M.D., 12000 Fairhill Road, Apt. 502, Cleveland, Ohio 44120. Madras University (India) 1966. Board certified. Subspecialty, gastroenterology. Group partnership, hospital, or solo. Available July 1975.

Joonhi Choi, M.D., 636 Brooklyn Ave., Apt. 8-H, Brooklyn, New York 11203. Seoul National University (Korea) 1964. Board certified. Subspecialty, hematology. Solo, group, or association. Available.

Stanley F. Bernstein, M.D., 406 Hillside Ave., Boonton, N.J. 07005. CMDNJ 1972. Board eligible. Group or partnership. Available July 1975.

Augustin J. Schwartz, III, M.D., 14163 Castle Blvd., Apt. 403, Silver Spring, Md. 20904. Jefferson 1971. Board certified. Subspecialty, oncology. Group or partnership. Available July 1975.

Hui-Yen Chang, M.D., Dept. of Dev. Therapeutics, Anderson Hospital, Houston, Texas 77025. Taipei (Taiwan) 1966. Board eligible. Subspecialty, oncology. Group, partnership, or hospital. Available July 1975.

Deepak Sagger, M.D., 4653 Walford Rd., Warrensville Hgts, Ohio 44128, Ludiana (India) 1970. Board certified. Solo, partnership, or group. Available June 1975.

Jerome H. Seigel, M.D., 9 Washington House, 20 Basil St., London SW 3, England. Georgia 1960. Subspecialty, gastroenterology and liver disease. Board eligible. Partnership or space-sharing. Available July 1975.

OBSTETRICS AND GYNECOLOGY—Iqbal Karim M.D., 509 Lafayette Ave., Apt. 6, Buffalo, N.Y. 14222. Dow (Pakistan) 1970. Solo, partnership, or group. Available July 1975.

ORTHOPEDIC SURGERY—Muhammad Umar, M.D., 1945-25G Eastchester Rd., Bronx, N.Y. 10461. King Edward (Pakistan) 1969. Board eligible. Group, partnership, or solo. Available July 1975.

PATHOLOGY—Lorraine Roth-Moyo, M.D., 101 Humber College Blvd., Toronto (Rexdale), Ontario, Canada. Ottawa 1970. Board certified—AP and CP. Hospital or group. Available Spring 1975.

PEDIATRICS—Isaac G. Doron, M.D. Stevens Clinic Hospital Apts., Welch, West Virginia 24801. Cairo University (Egypt) 1953. Board eligible. Group or partnership. Available.

Daniel J. Rowe, M.D., 27212 Calaroga Ave., Hayward, Calif. 94545. New Jersey School of Medicine, CMDNJ, 1965. Board certified. Group. June 1975.

Bhushan C. Gupta, M.D., 605 East 14th Street, Apt. 9-G, New York 10009. Amritsar (India) 1969. Subspecialty, pediatric allergy. Board eligible. Solo, associate, partnership. Available July 1975.

Hsinn-Hong Wang, M.D., 81-44 168th Street, Jamaica, New York 11432. Taiwan, 1967. Subspecialty, neonatology. Board eligible. Group, partnership, or hospital. Available July 1975.

RADIOLOGY—Christopher B. H. Gouw, M.D., 594 North St., Teaneck 07666. Indonesia 1961. Board eligible. Available July 1975.

SURGERY—Stephen Green, M.D., 6938 Post Street, Edwards AFB, California 93523. NYU 1966. Board certified. Solo or partnership, northeastern part of State. Available July 1975.

Steven A. Dressner, M.D., 435 E. 70th St., Apt. 9-K, N. Y. 10021. Cornell 1968. Board eligible. Subspecialty vascular surgery. Solo, group, partnership, hospital. Available May 1975.

Arieh Kaynan, M.D., 1249 Park Ave., Apt. 2-B, New York 10029. Hadassah (Israel) 1965. Board eligible. Subspecialty, vascular surgery. Group or institution. Available July 1975.

Hermenegildo D. Ante, M.D., 890 Berkshire Dr., Westbury, N.Y. 11590. Manila 1953. Board eligible. Group. Available.

Chi-Hong Yang, M.D., 2116 8th St., Cuyahoga Falls, Ohio 44221. Taipei 1970. Board eligible. Group, partnership, or solo. Available July 1975.

UROLOGY—J. M. DeCento, M.D., Woodbine Road, Shelburne, Vermont 05482. Vermont 1973. Association, Available July 1975.

Joel W. Goldsmith, M.D., 5700 Arlington Ave., Bronx, N.Y. 10471. SUNY Downstate 1971. Board eligible. Solo or partnership. Available July 1975.

Stefan Loening, M.D., 9500 Euclid Ave., Cleveland, Ohio 44106. Freiburg (Germany) 1965. Board eligible. Group, partnership, or solo. Available October 1975.

Aurelio Benavides, M.D., 733 Marshall Dr., Erie, Pa. 16505. Javeriana (Bogota, Colombia) 1970. Board eligible. Group or partnership. Available July 1975.

John R. Whittaker, M.D., 3411 Wayne Ave., Bronx, N.Y. 10467. Cincinnati 1969. Board eligible. Partnership or solo. Available July 1975.

Bhalchandra Dave, M.D., 230 Jay St., Brooklyn, N.Y. 11201. Gujarat (India) 1968. Associate, partnership, group, solo. Available 1975.

Medical Auditing at Veterans Administration Hospital

(The following report was prepared by J. T. Daniels, M.D., E. X. Freed, Ph.D., Joan Treuer, M.D., and Amy Conover, all of whom are associated with the Veterans Administration Hospital in Lyons, New Jersey.)

Anticipating the system-wide implementation of Problem Oriented Medical Recording (POMR) by the Veterans Administration, the Lyons V.A. Hospital developed and adopted its own system on June 1, 1974. This has proved advantageous from a number of points of view. The POMR increasingly is acknowledged as the most effective means of documentation of health care delivery. It is an organized, scientific approach and is essentially syllogistic in its reasoning; the records yielded readily lend themselves to review.

Because the traditional inspection, review, evaluation, and correction of randomly selected medical records by the Medical Record Committee seemed a less acceptable method for appraising the quality of medical care rendered in this hospital, it was replaced by a multidisciplinary Patient Care Appraisal Committee. This comprised two sub-groups. A Medical Record Subcommittee was charged with implementing a POMR system, composing this hospital's POMR manual, forms, and so on, and then utilizing locally established criteria for disease categories in identifying possible deficiencies or discrepancies. A Professional Subcommittee was made responsible for establishing these criteria for medical audit and for rendering final judgment on possibly deficient records referred by the Medical Record Subcommittee. Thus, the thrust was for the unique—but closely related—dual purposes of developing a POMR system simultaneously *for* medical auditing.

Not only have these two goals mutually influenced each other's development, but they have also interacted with medical education because the "bi-cycle" orientation to medical audit and continuing medical education was built in. This concept involves a process of matching actual performance by means of a formal audit of patients' records against a set of criteria determined locally. This is the "patient care" half of the cycle. Patient management deficiencies disclosed in this process serve as the basis for the "education" half of the cycle. This has been designed to provide information to the staff so that these deficiencies may be avoided. Learning thus becomes affirmative, goal-oriented, and reinforcing. Education, of course, began with the conversion of the hospital charting system to POMR. Now it continues with the Professional Subcommittee establishing diagnostic criteria. A diagnostic entity is scrutinized, it becomes clear that certain laboratory data are needed in addition to the complete physical examination and psychiatric evaluation required for all applicants for hospital services, the information is communicated to staff, and training accordingly is accomplished. Because criteria are developed for medical audit, in effect the Professional Subcommittee serves a utilization review function in which self-evaluation takes place. Continual self-improvement is intrinsic to this approach. For example, a POMR manual revision is planned within six months and comments, corrections, and suggestions for enhancing recording have been solicited from staff, which has already responded generously. Hospital personnel constantly provide input for the POMR. New flow sheets are devised to meet special needs on specialized units. Recording becomes streamlined.

Even though record review is retrospective, each audit is prospective in terms of becoming a learning situation. Uniformity of documentation of quality care is the goal with no attempt to standardize health care practice. Documentation in the patient's record constitutes the sole means of assessing quality of care after the patient has left the hospital. In medicolegal matters, timely and specific recordings are a *sine qua non*. Documentation of the highest quality is also mandatory for continuing hospital accreditation.

The POMR and medical audit systems, while yielding an end product, are also a process. The Lyons V.A. Hospital has approximately

900 psychiatric beds. On its psychiatric units, this hospital is committed to the multidisciplinary approach to patient care. This means that the staff members—psychiatrist, nurses, social worker, psychologist, *et al.*—on a unit, function as a team with team recording of data. POMR encourages communication between team members in initial assessment and treatment planning for patients and in discharge planning. Communication between teams and the Patient Care Appraisal Committee is also via two-way feedback. The POMR and the medical audit have become techniques for dialogue.

Some problems which have been encountered include technical and logistical ones. When should the records of long term patients be converted to the new system? Presently, the annual medical examination serves as a target date. If aspirations are to not equivocate with the best kind of record, then a completely typed chart is required and adequate support and transcription services are needed to furnish this documentation. Change in procedures is not easy to effect. Old learning is familiar, new habits are sometimes hard to acquire.

Encouraging research possibilities have not even been tapped. The POMR is amendable to computerization and a plethora of data reside in flow sheets and patients' data bases. Certainly, all sorts of statistical measuring devices would become available to clinicians, researchers, and to the hospital's administration.

Still embryonic, this hospital's whole approach has potential. Accountability in patient care is more meaningful than ever and, coupled with the sort of enthusiasm and motivation which resulted in adoption of the POMR simultaneously for medical auditing, only better health care delivery to patients can result.

Patronize Our Advertisers

The Scientific Exhibits — — 209th Annual Meeting

The following information is pertinent to the scientific exhibit display at the 209th Annual Meeting of this Society, May 31-June 3, 1975. Those interested in participating may use the application form on page 975. (Please complete both sides.) Remove the page from *The Journal* and mail directly to Francis X. Keeley, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Policy—It is the policy of the Committee on Scientific Exhibits of The Medical Society of New Jersey, in instances where a pharmaceutical company has aided in the production of an exhibit—either through financing or supplying products—that the name of the product or company is not to appear on any placards pertaining to the exhibit or on booth signs shown within the area of the exhibit, nor is it to appear in the description of the exhibit published in the program. However, the committee does not object to reprints of articles pertaining to the exhibit being distributed from the scientific exhibit booth. Scientific exhibitors are free to discuss with visitors to their booths products used in their presentations.

Space assigned will be an 8-foot deep booth (backwall and two sidewalls) of composition board covered with burlap. The backwall will vary according to the requirements of the exhibitor, and the measurement must be noted on the application. A shelf one foot wide is provided with each booth. The height of the wall above the shelf is 5 feet, 6 inches. However, the shelf will be removed if advance request is made. By eliminating the shelf, the booth will measure 8 feet in height.

Please indicate on the application if the exhibit is free-standing. Such an exhibit will not require a constructed booth.

Please indicate on the application if a sign is incorporated with your exhibit. If so, one will *not* be ordered.

If at all possible, a photograph of the exhibit should accompany the application. If a photograph is not available, a drawing will suffice.

Application for space in the Scientific Exhibit must be submitted no later than January 15, 1975, for consideration by the committee. Applications will be acted upon by the committee as soon after that date as possible and notification sent to all exhibitors. Send *completed* application, together with photograph or drawing of exhibit, to Francis X. Keeley, M.D., Chairman, Committee on Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton 08605.

1. *Time:* The exhibits will open officially at 12 noon, Saturday, May 31, and close at 5 p.m., Monday, June 2. On the intervening day the hours are 9 a.m. to 5 p.m.

2. *Installation and Dismantling:* Installation of exhibits may begin at 3 p.m., Friday, May 30, and all exhibits must be in place by 11 a.m., Saturday, May 31. Exhibits must remain intact until 5 p.m., Monday, June 2, and should be removed from the exhibit hall not later than 12 noon, Tuesday, June 3.

3. *Cost:* The Society provides free of charge such space exhibitor may require including booth with shelf printed sign (*if requested*), and lights for illumination. The exhibitor must pay the cost of installing the exhibit, of renting tables and chairs, and the alterations and special construction, *including electrical connections.*

4. *Sponsorship:* All exhibits must be shown in the name of individual persons. The name of the institution may appear as part of the address. Medical schools, hospitals, clinics, and other institutions and organizations should not present exhibits in their own names, but rather in the names of the individuals who worked up the exhibit.

5. *Use of Space:* No exhibit shall interfere with another exhibit. No part of the exhibit will be allowed to extend above the top of the booth.

6. *Aisles:* Aisles must be kept clear; to this end exhibits must be so arranged that they will be inside the booth space.

7. *Advertising:* No advertising matter of any description may be distributed, nor any material shown which in any way serves for commercial propaganda.

8. *Demonstrations:* All exhibits must be in charge of competent, well-informed demonstrators. The workers who did the actual work shown, or someone who is familiar with all details, **must be present at all times during exhibit hours.**

9. *Motion Pictures:* Motion pictures may be shown in booths. Films are subject to preview at the discretion of the committee. They shall be non-inflammable, and *silent.* The exhibitor must supply his own screen, projector, and operator.

10. *Liability:* It is agreed that exhibitors shall indemnify and hold blameless The Medical Society of New Jersey and Garden State Park Convention Center from all liability which may ensue from any cause whatsoever relating to the use of a booth by an exhibitor. Watchmen will be supplied, but MSNJ cannot guarantee exhibitors against loss. All valuable property should be insured by the exhibitor. MSNJ and the Committee on Scientific Exhibits neither endorse nor assume any responsibility for the contents of such exhibit.

11. *Awards:* Exhibits will be judged on the basis of originality, excellence of correlating facts, and excellence of presentation.

12. *Admission:* Admission to the Scientific Exhibits is by badge only. The general public is not admitted.

These regulations have become a part of the agreement between the exhibitor and The Medical Society of New Jersey. They have been formulated for the best interests of all concerned, and the cooperation of the exhibitors will be deeply appreciated.

THE MEDICAL SOCIETY OF NEW JERSEY

209th Annual Meeting

GARDEN STATE PARK CONVENTION CENTER, CHERRY HILL, NEW JERSEY

APPLICATION FOR SPACE IN THE SCIENTIFIC EXHIBITS

May 31-June 2, 1975

The Committee on Scientific Exhibits will furnish uniform, painted signs for each exhibit—if requested by exhibitor. Please fill in the following form carefully. (use *typewriter,* or *print,* please)

1. TITLE (Generic names only): .....

   .....

   Full Name and Degree of Exhibitor(s) .....

   .....

   City ..... State .....

   Institution (if desired) ..... City .....

   Aided by commercial or pharmaceutical company .....

   Exhibit constructed by: .....

2. DESCRIPTION OF EXHIBIT: Please give a brief statement telling the purpose of the exhibit, what it shows, and the conclusions reached—use generic names only. (This is for publication in the printed program.)

   .....

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   .....

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   .....

3. Is the exhibit free-standing or self-contained? .....
4. SIGN required: ..... SIGN *not* required: .....
5. Will backwall and dividers be required? (see sketch on reverse side): .....
6. SIZE OF BOOTH REQUESTED (See sketch on back) ABSOLUTE MAXIMUM: length 15′, depth 8′.

   Desired inside clear backwall (8 to 15 feet) ..... Minimum inside clear blackwall .....
7. PHOTOGRAPH OR SKETCH of exhibit should accompany this application. .....
8. Has this exhibit been shown in whole or part at any other scientific meeting? .....

   If so, when? ..... and where? .....

   The undersigned agrees to abide by the regulations listed.

Name .....

Address .....

Date: ....

Return application to Francis X. Keeley, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

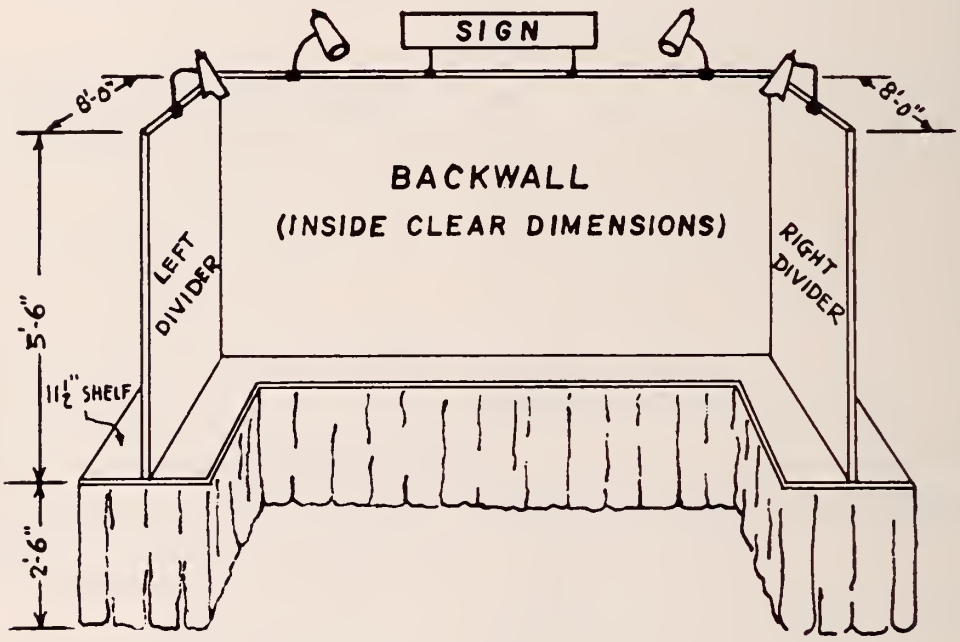
STANDARD EQUIPMENT REQUISITION FORM

Use this form only in connection with equipment to be supplied by the Committee on Scientific Exhibits. Equipment listed below will be provided at no charge to exhibitors. However, it is important that you anticipate your exact requirements in advance, as last minute changes are costly to the Society.

All scientific booths will be erected with backwall and dividers as illustrated below. Shelving and overhead lights are optional.

ILLUSTRATION OF TYPICAL BOOTH

(Booth construction: composition board covered with burlap)



Check appropriate boxes:	left divider		backwall		right divider	
Shelving	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no
Overhead lights	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no

If your exhibit will not require backwall, or left or right dividers, please advise.

If a sign is incorporated with your exhibit, please advise, and one will *not* be ordered for you.

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

Within a few weeks the first notices of acceptance for the freshman class of 1975-76 at medical schools throughout the country will be on their way to hopeful candidates. If last year's statistics continue to apply, three-fourths of New Jersey applicants will not be accepted.

The disappointed ones will ask "why," and obviously there is no answer that will satisfy all of them—if any of them. Here's how we at the College of Medicine and Dentistry of New Jersey respond when questions arise on this subject:

"To help insure getting into medical or dental school, the candidate must show people interest.

"Of course grades and test scores are important," Dr. Joseph P. Tassoni, dean of admissions of our CMDNJ-New Jersey Medical School, Newark, has said, "but when the chips are down, we look for men and women who are people-oriented, who are highly motivated, and who have concretely demonstrated a very strong desire to become a doctor by extra-curricular research, by working in a hospital or other health-care activity, or by socially-oriented volunteer activities.

"The reality of the situation is that there just aren't enough spaces, either in New Jersey or nationwide, for all who apply to professional schools. So there's certainly no room for anyone with only a superficial interest, no matter how good his grades."

Dean Tassoni's words are echoed by Dr. Lawrence T. Taft and Dr. Carmine J. LoMonaco, who are deans of admissions, respectively, at CMDNJ-Rutgers Medical School, Piscataway, and CMDNJ-New Jersey Dental School, Jersey City.

"The difference between an acceptance and a rejection is often very small," according to Dean Taft. "It may well be demonstrated interest, desire, and ability to work with people."

"Dental schools are no different than medical schools regarding admissions," Dean LoMonaco adds. "Anyone can state an interest, but persuading the admissions committee that the interest is real and pervading is crucial to the successful candidacy. We want more in a candidate than just working hard to get good grades, important though that may be. The extra that can make the difference is people interest. That's the mark of a professional."

The College of Medicine and Dentistry of New Jersey has accepted 283 students—88 percent of them from New Jersey—in its 1975-76 freshman classes: 111 at CMDNJ-New Jersey Medical School, 108 at CMDNJ-Rutgers Medical School, and 64 at CMDNJ-New Jersey Dental School, a college-wide increase of 16 over 1973-74.

In addition, NJMS has taken in 22 third-year transfer students, mostly residents of New Jersey, whose first two years of medical study were done abroad. Our "Fifth Channel" program for returning U.S. foreign medical graduates has also been expanded from 51 to 76 clinical students.

RMS is also increasing the size of its third-year class as part of the transition from a two-year to a four-year school. Last year there were 34 juniors; the number this year is 56. Thus there has been an internal increase in potential M.D. graduates.

Eventually, after expansion programs are completed, CMDNJ may have double the 900-odd full-time students it had in its medical and dental schools last June.

"For the young man or woman seeking admission today, 'eventually' is a long way off," Dr. Tassoni said. "Meanwhile, New Jerseyans are in a particular squeeze, and there's no 'tomorrow' solution in sight."

The plight of residents of New Jersey, one of the most densely populated states in the country, stems in part from the fact that it had no medical school for most of its existence. The College of Medicine and Dentistry of New Jersey, as it is today, was established by an act of the State Legislature in 1970.

"Because of the population problem and other factors, ours are the hardest medical schools in the country to get into," Dr. Charles Vevier, CMDNJ's executive vice president, said, "and because we can take only a few out-of-state residents, other states are apparently reluctant to open up many places to New Jersey residents. Pressures from other State Legislatures add to the problem."

The new NJMS class has a 3.6 scholastic average (of a possible 4.0), and 600 board scores, yet many of our rejection notices went out to young people in similar range.

Screening of applicants is in the hands of com-

mittees of faculty members and students. The first step is to cull the lists on the basis of grades, test scores, and recommendations of the student's college pre-medical/pre-dental committee. Dr. Tassoni said that in some cases, grade averages of successful candidates may be slightly below those of applicants who don't make it. An evaluation is made of the meaning of each grade average by consideration of such factors as the undergraduate institution.

Women are being admitted to CMDNJ classes in increasing numbers, but the percentage of women applying to medical school remains relatively small, about one-eighth of the number of male applicants. Women are not flocking to apply to dental school, either. However, CMDNJ-New Jersey Dental School has enrolled nine women in its new class, compared to six the year before and one in 1969. At 14 percent, the first-year class has seven times more women than the national average. Dr. LoMonaco attributed the increased enrollment of women to "trends both in society and in the dental profession, and to the fact that we actively seek out qualified women candidates."

Dr. O'Regan, Medical Director, NJFHCE

Daniel J. O'Regan, M.D. has been appointed Medical Director of the New Jersey Foundation for Health Care Evaluation. Born in Jersey City, Dr. O'Regan was graduated from Georgetown University School of Medicine in 1947. Following active duty with the U.S. Navy during the Korean War, he completed his residency in orthopedic surgery at Georgetown University Hospital and began practice in Jersey City in 1954. He was certified by the American Board of Orthopedic Surgery in 1957. In addition to membership in the Hudson County Medical Society, MSNJ, and the AMA, he is a Fellow of the American College of Surgeons and of the International College of Surgeons and a member of the American Academy of Orthopedic Surgeons, American Academy of Cerebral Palsy, the Academy of Medicine of New Jersey, and the New Jersey Orthopedic Society of which he is a past-president. Dr. O'Regan assumed his duties with the Foundation on November 1st. He is on leave of absence from the St. Francis Community Health Center in Jersey City where he is a past-president of the medical staff.

Dr. O'Regan and his wife, the former Sue-Clare Burkhart of Ohio, are the parents of a twelve-year-old son, Michael.

LETTER TO THE JOURNAL

Dispensing Medicine in School

September 30, 1974

Dear Sir:

In response to your editorial on dispensing medicine in school, I thought you might be interested in our attempt in the Ewing Public School System (Trenton) to answer at least part of the question. Below is an abstract of a letter to all doctors in our surrounding communities, who would have occasion to treat Ewing students, and reproduction of a communication sent to the parents.

I, also, think that it would be too much responsibility to ask the nurses to diagnose and treat potential emergencies that might arise during the school year. Every patient is a malpractice threat, no matter how good your intentions, nor how successful a result you may have obtained in treating an emergency. The time involved and mental anguish of being named in a malpractice suit deter aggressive treatment. Children in many school districts cannot be given even an aspirin because of the danger of an allergic reaction and the possible threat of a suit against the nurse, the doctor, and the school district. This is a disgrace, but one can see the logic behind such rulings.

I might add that our program thus far has worked well with good cooperation from the doctors. To date, we have not had to challenge any of them for their judgment in prescribing medication to be administered through the school hours; although I do believe that there could be more use of the so-called prolonged-acting or delayed-action medications, particularly in allergies, coughs (Tussionex) and the ever-present URI's.

(signed) Charles W. Burroughs, M.D.

Abstract of Letter to Physicians re Policy for Administering Medications in School:

Parents should arrange with the family physician for medicine to be given *outside of school hours.* Since most medication today can be of a long-acting type (given every eight to twelve hours), there is little reason for students to bring medicines to school. If, however, the family doctor advises that the health of the child is such that he could and should attend school and must have medicine administered during school hours, a *written* notification is required from the private physician on the *forms provided by the school.* The completed form, with the medication in a prescription bottle and labeled with name, date, and content must be presented to the school nurse before the nurse will administer the medication to the child. Parents will be advised to obtain the medication permission slip from the school nurse before the child is seen by the family physician.

Date _____

Dear Parent:

If it is necessary for your child to take any medication at school during school hours, would you and your child's medical doctor kindly fill out the slip below. Whenever possible, the taking of the medication should be timed so that the medicine is taken at home, before and after school hours.

_____
School Nurse

I hereby request permission for my child _____
Name
_____ a student at _____ to be
School
given prescription medication at school, during school hours. In doing so, I release the Ewing Township nurses, physicians, and the Ewing School System of any and all responsibility for any and all untoward reactions my child may incur as a result of taking said medication. I have obtained the following instructions from my child's doctor: (To be filled in and signed by doctor)

1. Diagnosis _____
2. Dosage _____
3. Name of Medication _____
4. Time during school hours when medication is to be taken _____
5. Beginning date is _____
   Last day is _____

Date _____

_____
Doctor's Signature

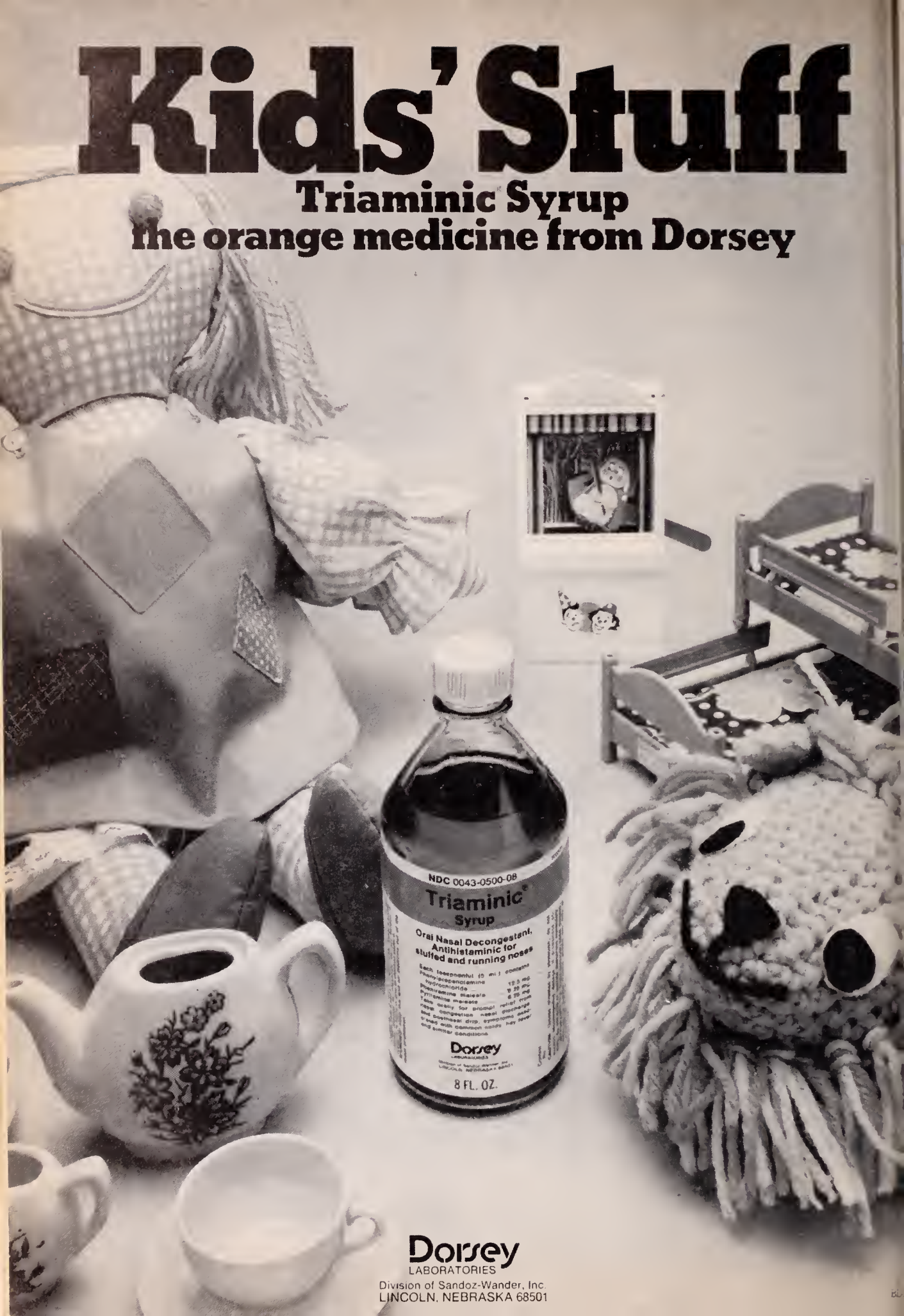
_____
Doctor's Name (typed or printed)

I shall send the appropriate amount of the medication to the school. _____
Parent's Signature

Approved by Medical Inspector
Ewing Township Public Schools

Kids' Stuff

Triaminic Syrup
The orange medicine from Dorsey



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ANNOUNCEMENTS

Current Topics in Psychiatry

The Fair Oaks Hospital in Summit announces the following programs in the 1974-1975 series on current topics in psychiatry. Dates and topics of subsequent sessions will be announced in future issues of *The Journal.*

Dec. 4—Medical-Legal Aspects of Medicine
Jan. 8—New Developments in Scanning
Jan. 22—The Special Patient Syndrome

Sessions are held from 3 to 4:30 p.m. in the Conference Room at the Hospital (19 Prospect Street). Granville L. Jones, M.D., Director of Research and Education at Fair Oaks, will be moderator and further information is available by writing directly to him.

The programs are cosponsored by the Academy of Medicine and are accredited for Category I of the AMA Physician's Recognition Award.

Training Program for Emergency Department Physicians

In cooperation with the Inter-Agency Commission on Emergency Medical Care, MSNJ will sponsor a training program for emergency department and other interested physicians in each of the Society's Judicial Districts from 9 a.m. to 4 p.m. on three successive Wednesdays, as indicated. (A similar course has been arranged for nurses at Morristown Memorial, Dover General, St. Peter's (New Brunswick), Jersey Shore (Neptune), and Burlington County Hospitals.)

The series consists of lectures and demonstrations and the subjects included cover resuscitation of the severely injured patient, burns, emergencies of the chest and abdomen, musculoskeletal injuries, the unconscious patient, and psychiatric emergencies.

1st District	December 4 December 11	St. Elizabeth Hospital Elizabeth
2nd District	December 11 December 18 January 8	St. Joseph's Medical Center Paterson
3rd District	January 29 February 5 February 12	St. Francis Hospital Trenton
4th District	January 8 January 15 January 22	Monmouth Medical Center Long Branch
5th District	November 20 December 4 December 11	The Cooper Hospital Camden

Each course is limited to 100 persons and registration is required. Applications were mailed to each physician last month. The programs have been approved for Category I, AMA Physician's Recognition Award. For further information, please communicate with Jack R. Karel, M.D., Chairman, Inter-Agency Commission on Emergency Medical Care, 115 North Avenue, Hillside, New Jersey 07205.

Neuroscience Unit Conferences

The Neuroscience Unit of the Bergen Pines County Hospital in Paramus announces the following programs in its series of conferences. Additional programs will be listed in a later issue of *The Journal.*

December 9	Neurology-Neurosurgery Conference Warren Foer, M.D.
December 16	Basic Principles of Cerebral Palsy Harvey Merless, M.D.
January 6	Neurology-Neurosurgery Conference Warren Foer, M.D.
January 13	Seizure Disorders Michael Gruber, M.D.

Sessions are held from 11:30 a.m. to 12:30 p.m. in the auditorium at the hospital. Accreditation for Category I of the AMA Physicians' Recognition Award is pending. For additional information, please communicate with Leonard J. Lyon, M.D., Codirector of Medical Education at Bergen Pines County Hospital Paramus 07652.

Pulmonary Disease Lectures

The Veterans Administration Hospital in East Orange and the New Jersey Medical School, CMDNJ are cosponsors of a 1974-1975 series of lectures in pulmonary diseases, to be held on Wednesdays at 11:30 a.m. at the Veterans Administration Hospital, East Orange, on the dates indicated.

December 18	Emergency Pulmonary Care
January 15	Rifampin, Tuberculin
February 19	Chemical Control of Respiration
March 19	Cor Pulmonale
April 16	Infectiousness of Tuberculosis before and after Chemotherapy
May 14	Respiratory Failure

Symposium on Smoking and Health

A symposium outlining the latest information on smoking and health will be presented at the Hahnemann Medical College (Geary Auditorium) on Tuesday, January 14, 1975 at 1 p.m. The program is designed especially for general practitioners but is open to all physicians and members of house staffs. Four hours of Category I credit will be awarded to those in attendance. Sponsors are the Greater Philadelphia Interagency Council on Smoking and Health and the Department of Radiation Therapy and Nuclear Medicine of Hahnemann. Keynote speaker is Luther Terry, M.D., former Surgeon-General and now Professor of Community Medicine at the University of Pennsylvania. Other speakers are faculty members from Hahnemann, Jefferson, and University of Pennsylvania Medical Colleges. Registration fee is $5 and should be sent to Carl Karsch, Department of Radiation Therapy and Nuclear Medicine at Hahnemann Hospital, 230 North Broad Street, Philadelphia 19102.

Ophthalmic and Otolaryngic Plastic Surgery

Thailand, Malaysia, and Singapore are the locale for the Seventh International Congress on Ophthalmic and Otolaryngic Plastic Surgery, March 6th to 23rd, 1975. Subjects to be considered are Reconstruction of the Ear—New Approach to Dacryocystorhinostomy; Reconstructive Surgery of the Eyelids and Nose—Nasopharyngeal Carcinoma; and Plastic Surgery of the Orbit. In addition, ward rounds and case presentations will be conducted at hospitals and medical schools in Bangkok, Kuala Lumpur, and Singapore. Participating from the United States will be Wendell Hughes, M.D., former Associate Professor of Ophthalmology at Columbia University; Kurt F. Wagner, M.D., Attending Plastic Surgeon at Cedars of Lebanon Hospital in Los Angeles; and Ralph L. Dicker, M.D., Chief of Plastic Surgery at Riverside Hospital, Attending in Plastic Surgery at Dover General and St. Clare's Hospitals, and Director of the New York Facial Plastic and Reconstructive Surgery Group. There will be opportunity for a stopover at the Island of Bali in Indonesia and for a visit to Tokyo, Japan. Travel information and other details are available from International Professional Meeting Coordinators, 49 West 57th Street, New York 10019.

Physicians' Relief Fund

The Physicians' Relief Fund of The Medical Society of New Jersey is available to members of MSNJ in need of financial assistance in time of emergency or catastrophe. Applications are made through your county medical society—write or call the Secretary or the Executive Secretary for information.

Erratum

Referring to the Case Report on page 859 of the November 1974 issue, JMSNJ, "Echinococcus Cyst of the Liver in New Jersey: Treated by Left Hepatic Lobectomy," Gabriel M. Mulcahy, M.D., Director of the Department of Pathology, Jersey City Medical Center, should have been included as one of the authors, for supplying the photograph of the specimen (figure 4).

MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

Dec.

9, 16, 23, 30 **Distinguished Lectures in Surgery**
4-5 p.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

10 **Temporomandibular Joint Dysfunction and Ear Symptomatology**
6-10 p.m.—Valley Hospital, Ridgewood
(Sponsored by Bergen County Society of Otolaryngologists and Academy of Medicine)

10 **Laboratory Interpretations**
9 p.m.—Bayonne Hospital
(Sponsored by Academy of Medicine)

10 **Immuno-Deficient Children**
8:30-10 a.m.—Chilton Memorial Hospital, Pompton Plains
(Sponsored by Allergy Society of New Jersey and Academy of Medicine)

10 **Chemotherapy of Malignant Disease**
10:30 a.m.—North Hudson Hospital, Weehawken
(Sponsored by Academy of Medicine)

11 **Radioimmunoassays in Clinical Practice**
1-5 p.m.—Roche Laboratories, Nutley
(Sponsored by Academy of Medicine and Roche Laboratories)

11 **Emergency Department Training Program**
10 a.m.-3:30 p.m.—Cooper Hospital, Camden
(Sponsored by Interagency Commission on Emergency Medical Care, Cooper Hospital, and Academy of Medicine)

11 **Neuropharmacology of Parkinsonism**
6 p.m. (cocktails and dinner); 8 p.m. (program)—Holiday Inn, East Orange
(Sponsored by Academy of Medicine)

11 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)

11, 18 **Clinical Endocrinology**
3:30 p.m.—Martland Hospital, Newark, Beth Israel, and VA Hospital, East Orange (varies)
(Sponsored by Middlesex General Hospital and Academy of Medicine)

11, 18 **Office Proctology**
Androgen and Virilizing Syndromes
Mineralocorticord Hypertension
9-11 a.m.—Middlesex General Hospital, New Brunswick

11, 18 **1974-75 Lecture Series**
9-11 a.m.—Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and Academy of Medicine)

11, 18 **Distinguished Lectures in Neuroscience**
10:30-11:30 a.m.—VA Hospital, East Orange
(Sponsored by New Jersey Medical School, CMDNJ, East Orange VA Hospital, and Academy of Medicine)

12, 19, 26 **Clinical Nephrology**
4-5 p.m.—Martland Hospital Unit, Newark
(Sponsored by New Jersey Medical School, CMDNJ, and Academy of Medicine)

12 **Diagnostic Radiology**
8-10 p.m.—Helene Fuld Hospital, Trenton
(Sponsored by Diagnostic Radiology Section of Southern New Jersey and Academy of Medicine)

12 **Trauma**
Memorial General Hospital, Union
(Sponsored by Academy of Medicine)

13 **Current Burn Treatment**
12:15-1:15 p.m.—Zurbrugg Memorial Hospital, Riverside
(Sponsored by Academy of Medicine)

14, 21, 28 **Basic Science for Surgeons**
10 a.m.-12 noon—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

14, 21, 28 **Orthopedic Surgery**
8:30 a.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

16 **Fluid and Electrolyte Imbalance**
8 p.m.—Irvington General Hospital, Irvington
(Sponsored by Academy of Medicine)

16 **Differential Diagnosis of Arthritis**
11:30 a.m.—Helene Fuld Hospital, Trenton
(Sponsored by Academy of Medicine)

17 **Fluid and Electrolyte Imbalance**
11:30 a.m.—St. Mary's Hospital, Orange
(Sponsored by Academy of Medicine)

17 **Emergencies in Psychiatric Practice**
11 a.m.—Greystone Park Psychiatric Hospital,
(Sponsored by Academy of Medicine)

17 **Cardiac Arrhythmias**
Hospital Center at Orange, Orange
(Sponsored by Academy of Medicine)

18 **Emergency Pulmonary Care**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

18 **Proper Use of Antibiotics**
10 a.m.—St. James Hospital, Newark
(Sponsored by Academy of Medicine)

18 **Joint Monthly Sessions of Clinical Interest**
7-9 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)

18 **Medical-Legal Aspects of Medicine**
1 p.m.—Trenton Psychiatric Hospital
(Sponsored by Academy of Medicine)

24 **Insect Bites**
8:30-10 a.m.—Chilton Memorial Hospital, Pompton Plains
(Sponsored by New Jersey Society and Academy of Medicine)

24 **Hypersensitive Lung Disease**
10 a.m.-12 noon—Perth Amboy General Hosp.
(Sponsored by Allergy Society of New Jersey and Academy of Medicine)

Jan.
2 **Clinical Nephrology**
9 4-5 p.m.—Martland Hospital Unit, Newark
16 *(Sponsored by CMDNJ, New Jersey Medical*
23 *School, and Academy of Medicine*
30

4 **Orthopedic Surgery**
11 8:30 a.m.—Martland Hospital, Newark
18 *(Sponsored by CMDNJ, New Jersey Medical*
25 *School, and Academy of Medicine)*

4 **Basic Science for Surgeons**
11 10 a.m.-12 noon—Martland Hospital, Newark
18 *(Sponsored by CMDNJ, New Jersey Medical*
25 *School, and Academy of Medicine)*

6 **Diagnostic Radiology**
8-10 p.m.—Hunterdon Medical Center, Flemington
(Sponsored by Diagnostic Radiology Section of Southern New Jersey and Academy of Medicine)

6 **Distinguished Lectures in Surgery**
13 4-5 p.m.—Martland Hospital, Newark
20 *(Sponsored by CMDNJ, New Jersey Medical*
27 *School, and Academy of Medicine)*

7 **Modern Theories of Aging—4-6 p.m.**
14 **Genetic Aspects of Aging Process—4-5 p.m.**
14 **Cellular Mechanisms of Aging Process—5-6 p.m.**
21 **Free Radical Mechanism of Aging Process—4-5 p.m.**
21 **Metabolic Changes in Senescence—5-6 p.m.**
28 **Obesity and Age-Related Changes in Lipid Metabolism—4-5 p.m.**
28 **Age-Related Alterations in the Immune System—5-6 p.m.**
Martland Hospital, Newark
(Sponsored by New Jersey Medical School, CMDNJ)

8 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital
(Sponsored by New Jersey Radiological Society and Academy of Medicine)

8 **Proper Use of Blood Gases**
10 a.m.—St. James Hospital, Newark
(Sponsored by Academy of Medicine)

8 **New Developments in Scanning**
3 p.m.—Fair Oaks Hospital, Summit
(Sponsored by Academy of Medicine)

8 **Portal Hypertension**
12 noon-4:30 p.m.—Hamilton Hospital, Trenton
(Sponsored by Hamilton Hospital)

8 **Advances in Medicine**
15 9:30-11 a.m.—Bergen Pines County Hospital,
22 Paramus
29 *(Sponsored by Bergen Pines County Hospital and Academy of Medicine)*

8 **Distinguished Lectures in Neuroscience**
15 10:30-11:30 a.m.—VA Hospital, East Orange
22 *(Sponsored by CMDNJ, New Jersey Medical*
29 *School, VA Hospital at East Orange, and Academy of Medicine)*

8 **1974-75 Medical Lecture Series**
15 9-11 a.m.—Riverview Hospital, Red Bank
22 *(Sponsored by Riverview Hospital and the*
29 *Academy of Medicine)*

8 **Drug Management of Coronary Arterial Disease**
15 **Portal Hypertension**
22 **Inflammatory Bowel Disease**
29 **Common Disease of Travelers**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

8 **Clinical Endocrinology**
15 3:30 p.m.—Martland Hospital, Newark Beth
22 Israel, and VA Hospital, East Orange (varies)
29 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

9 **Medical Care in the Emergency Room**
1 p.m.—Ancora Psychiatric Hospital, Hammonton
(Sponsored by Academy of Medicine)

10 **Chronic Lung Disease**
11:30 a.m.—Helene Fuld Hospital, Trenton
(Sponsored by Academy of Medicine)

14 **Renal Failure**
8 p.m.—Paul Kimball Hospital, Lakewood
(Sponsored by Paul Kimball Hospital and Academy of Medicine of New Jersey)

14 **Cutaneous Manifestations of Systemic Disease**
8 p.m.—White Laboratories, Schering Corporation
(Sponsored by New Jersey Dermatology Society and Academy of Medicine)

14 **Fluid and Electrolyte Imbalance**
10:30 a.m.—North Hudson Hospital, Weehawken
(Sponsored by Academy of Medicine)

15 **Joint Monthly Sessions of Clinical Interest**
7-9 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)

15 **Proper Use of Antibiotics**
2 p.m.—Cherry Hill Medical Center, Cherry Hill
(Sponsored by Academy of Medicine)

15 **Neurology**
1 p.m.—Trenton Psychiatric Hospital, Trenton
(Sponsored by Academy of Medicine)

15 **Rifampin, Tuberculin**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

15 22 29 **Clinical Interpretation of Diagnostic Laboratory Tests**
3:30-5:30 p.m.—Rutgers Medical School, CMDNJ, Piscataway
(Sponsored by CMDNJ, Rutgers Medical School and Academy of Medicine)

17 **Alcoholism**
9 a.m.—St. Elizabeth Hospital, Elizabeth
(Sponsored by Academy of Medicine)

20 **Medical-Legal Aspects of Medicine and Surgery**
8 p.m.—Irvington General Hospital, Irvington
(Sponsored by Academy of Medicine)

21 **Laboratory Interpretations**
11:30 a.m.—St. Mary's Hospital, Orange
(Sponsored by Academy of Medicine)

21 **Chest Case Conferences**
7:30 p.m.—VA Hospital, East Orange
(Sponsored by New Jersey Thoracic Society and Academy of Medicine)

21 **Cardiac Surgery and Anesthesiology**
6-9 p.m. (dinner meeting)—Ramada Inn, Clark
(Sponsored by New Jersey Society of Anesthesiologists and Academy of Medicine)

23 **Coronary Arteriography: Part I**
7:15-10:15 p.m.—Hospital Center at Orange
(Sponsored by Radiology Society of New Jersey and Academy of Medicine)

24 **Gastrointestinal Bleeding**
12:15 p.m.—Zurbrugg Memorial Hospital, Riverside
(Sponsored by Academy of Medicine)

28 **Neurology**
11 a.m.—Perth Amboy General Hospital, Perth Amboy
(Sponsored by Academy of Medicine)

28 **Breast Cancer**
8 p.m.—Warren Hospital, Phillipsburg
(Sponsored by Academy of Medicine)

Feb.

1 8 15 22 **Orthopedic Surgery**
8:30 a.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

1 8 15 22 **Basic Science for Surgeons**
4-5 p.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

3 10 17 24 **Distinguished Lectures in Surgery**
4-5 p.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

3 **Practical Dermatology**
8 p.m.—Community Memorial Hospital, Toms River
(Sponsored by Academy of Medicine)

4 **Changes in Functional Adaptation—4-6 p.m.**

11 **Pathology in Aged as Opposed to Pathology of Aging—4-5 p.m.**
11 **Cardiovascular Aspects of Aging—5-6 p.m.**
18 **Hemodynamic Changes Associated with Aging—4-5 p.m.**
18 **Atherosclerosis—5-6 p.m.**
25 **Electrocardiography and other Diagnostic Procedures in the Aged—4-5 p.m.**
25 **Gastrointestinal Changes in the Aging —5-6 p.m.**
Martland Hospital, Newark
(Sponsored by Academy of Medicine)

5 **Neurology**
3 p.m.—Fair Oaks Hospital, Summit
(Sponsored by Academy of Medicine)

5 **Albert Siegel Symposium—Liver Disease**
2-5 p.m.—St. Barnabas Medical Center, Livingston
(Sponsored by New Jersey Gastroenterological Society and Academy of Medicine)

5 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 12 19 26 **Clinical Endocrinology**
3:30 p.m.—Martland Hospital, Newark Beth Israel, and VA Hospital, East Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 **Common Protozoal and Fungal Infections**
12 **Future of Allergy**
19 **Hemostasis**
26 **Hypercalcemia and Hyperparathyroidism**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

5 12 19 26 **1974-75 Medical Lecture Series**
9-11 a.m.—Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and Academy of Medicine)

5 12 19 26 **Clinical Interpretation of Diagnostic Laboratory Tests**
3:30-5:30 p.m.—Rutgers Medical School, CMDNJ, Piscataway
(Sponsored by CMDNJ, Rutgers Medical School and Academy of Medicine)

5 12 19 26 **Distinguished Lectures in Neuroscience**
10:30-11:30 a.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)

6 13 20 27 **Clinical Nephrology**
4-5 p.m.—Martland Hospital Unit, Newark
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

11 **Genetic Disorders**
8 p.m.—White Laboratories, Schering Corporation
(Sponsored by New Jersey Dermatological Society and Academy of Medicine)

12 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown

(Sponsored by Radiological Society of New Jersey and the Academy of Medicine)

12 Advances in Medicine
19 9:30-11 a.m.—Bergen Pines County Hospital, Paramus
26 *(Sponsored by Bergen Pines County Hospital and Academy of Medicine)*

18 Medical-Legal Aspects of Medicine and Surgery
11:30 a.m.—St. Mary's Hospital, Orange
(Sponsored by Academy of Medicine)

18 Laboratory Interpretations
12 noon—Hospital Center at Orange
(Sponsored by Academy of Medicine)

19 Proper Use of Antibiotics
1 p.m.—Trenton Psychiatric Hospital, Trenton
(Sponsored by Academy of Medicine)

19 Hypertension
1:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(Sponsored by Academy of Medicine)

19 Joint Monthly Sessions of Clinical Interest
7-9 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, VA Hospital of East Orange, and Academy of Medicine)

19 Chemical Control of Respiration
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

20 Chest Case Conferences
7:30 p.m.—Mountainside Hospital, Montclair
(Sponsored by New Jersey Thoracic Society and Academy of Medicine)

21 Gastrointestinal Bleeding
12 noon—Freehold Area Hospital, Freehold
(Sponsored by Academy of Medicine)

21 Chemotherapy of Malignant Disease
9 a.m.—St. Elizabeth Hospital, Elizabeth
(Sponsored by Academy of Medicine)

27 Coronary Arteriography: Part II
7:15-10:15 p.m.—Hospital Center at Orange
(Sponsored by Radiology Society of New Jersey and Academy of Medicine)

Mar.
1 Orthopedic Surgery
8 8:30 a.m.—Martland Hospital, Newark
15 *(Sponsored by CMDNJ, New Jersey Medical*
22 *School, and Academy of Medicine)*
29

1 Basic Science for Surgeons
8 10 a.m.-12 noon—Martland Hospital, Newark
15 *(Sponsored by CMDNJ, New Jersey Medical*
22 *School, and Academy of Medicine)*
29

3 Proper Use of Antibiotics
8 p.m.—Community Hospital, Toms River
(Sponsored by Academy of Medicine)

3 Proper Use of Antibiotics
11:30 a.m.—Helene Fuld Hospital, Trenton
(Sponsored by Academy of Medicine)

3 Distinguished Lectures in Surgery
10 4-5 p.m.—Martland Hospital, Newark
17 *(Sponsored by CMDNJ, New Jersey Medical*
24 *School, and Academy of Medicine)*
31

4 Nutritional Aspects in Gerontology I—4-5 p.m.
4 Nutritional Aspects in Gerontology II—5-6 p.m.
11 Regressive Changes in Oral Cavity in Aged—4-5 p.m.
11 Effects of Aging on Endocrine System—5-6 p.m.
18 Reproductive Changes in Senility—4-5 p.m.
18 Musculo-skeletal Changes and Rehabilitation in Aged—5-6 p.m.
25 Dermatological Changes in Old Age—4-5 p.m.
25 Developmental Changes in Renal Function—5-6 p.m.
Martland Hospital, Newark
(Sponsored by Academy of Medicine)

5 1974-75 Medical Lecture Series
12 9-11 a.m.—Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and Academy of Medicine)

5 Clinical Endocrinology
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 Acupuncture
2 p.m.—Christ Hospital, Jersey City
(Sponsored by Academy of Medicine)

5 Advances in Medicine
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital and Academy of Medicine)

5 Monthly Meeting
8-10 p.m.—St. Joseph's Hospital and Medical Center, Paterson
(Sponsored by New Jersey Gastroenterological Society)

5 Distinguished Lectures in Neuroscience
12 10:30-11:30 a.m.—VA Hospital, East Orange
19 *(Sponsored by CMDNJ, New Jersey Medical*
26 *School, VA Hospital, East Orange, and Academy of Medicine)*

5 Clinical Endocrinology
12 3:30 p.m.—Martland Hospital, Newark Beth
19 Israel, and VA Hospital, East Orange (varies)
26 *(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)*

5 Heart Block and Syncope
12 Renal Failure
19 Resuscitation in Shock and Trauma
26 Office Urology
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

5 Clinical Interpretation of Diagnostic Laboratory
12 Tests
19 3:30-5:30 p.m.—Rutgers Medical School, Pis-
26 cataway
(Sponsored by CMDNJ, Rutgers Medical School, and Academy of Medicine)

6 Care of the Critically Ill Patient-Cardiac Arrests

1 p.m.—Ancora Psychiatric Hospital, Hammonton
(Sponsored by Academy of Medicine)

6, 13, 20, 27 **Clinical Nephrology**
4-5 p.m.—Martland Hospital Unit, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

8, 9 **Anesthesiology Seminar**
Cherry Hill Inn, Cherry Hill
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

11 **Dermatologic Manifestations of Endocrine Tumors**
8 p.m.—White Laboratories, Schering Corporation
(Sponsored by New Jersey Dermatology Society and Academy of Medicine)

11 **Endotoxic Shock**
11 a.m.—Margaret Hague Maternity Hospital, Jersey City
(Sponsored by Academy of Medicine)

11 **Emergency Room Medical Care**
10:30 a.m.—North Hudson Hospital, Weehawken
(Sponsored by Academy of Medicine)

12 **Multiple Sclerosis, Demyelinating Diseases**
VA Hospital, East Orange
(Sponsored by Academy of Medicine)

12 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and the Academy of Medicine)

17 **Proper Use of Antibiotics**
8 p.m.—Irvington General Hospital, Irvington
(Sponsored by Academy of Medicine)

19 **Psychiatry; Family Therapy**
1 p.m.—Trenton Psychiatric Hospital, Trenton
(Sponsored by Academy of Medicine)

19 **Medical-Surgical Emergencies in Psychiatric Practice**
1:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(Sponsored by Academy of Medicine)

19 **The Rights of Childhood**
8-10 p.m.—81 Grand Avenue, Englewood
(New Jersey Medical Women's Association)

19 **Joint Monthly Sessions of Clinical Interest**
7-9 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)

19 **Cor Pulmonale**
11:30-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School and Academy of Medicine)

20 **Renal Failure**
Somerset Hospital, Somerville
(Sponsored by Nephrology Society of New Jersey, New Jersey Regional Medical Program, Inc., Somerset Hospital, and Academy of Medicine)

20 **Chest Case Conferences**
7:30 p.m.—Overlook Hospital, Summit
(Sponsored by New Jersey Thoracic Society and Academy of Medicine)

21 **Renal Failure**
12:15 p.m.—Zurbrugg Memorial Hospital, Riverside
(Sponsored by Academy of Medicine)

21 **Fluid and Electrolyte Imbalance**
12 noon—Freehold Area Hospital, Freehold
(Sponsored by Academy of Medicine)

21 **Proper Use of Antibiotics**
9 a.m.—St. Elizabeth Hospital, Elizabeth
(Sponsored by Academy of Medicine)

25 **Mycologic Disease Syndromes**
11 a.m.—Perth Amboy General Hospital, Perth Amboy
(Sponsored by Academy of Medicine)

25 **Laboratory Interpretations**
8 p.m.—Warren Hospital, Phillipsburg
(Sponsored by Academy of Medicine)

27 **Sialography**
7:15-10:15 p.m.—Hospital Center at Orange
(Sponsored by Radiology Society of New Jersey and Academy of Medicine)

Apr.

1 **Renal Function in the Aged—4-5 p.m.**
1 **Changes in Pulmonary Function with Age—5-6 p.m.**
8 **Response of Aged to Operative Stress—4-5 p.m.**
22 **Neurological Changes During Senility—4-5 p.m.**
22 **The Aging Eye—5-6 p.m.**
29 **Panel Presentation—Aging, Dying, Death—4-6 p.m.**
Martland Hospital, Newark
(Sponsored by Academy of Medicine)

2 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

2 **Common Errors in Practice**
9 **Medical Hypnosis**
16 **Functional Diseases**
23 **Interaction of Drugs Used in Cardiac Disease**
30 **Stroke Rehabilitation**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

2, 9, 16, 23, 30 **Clinical Endocrinology**
3:30 p.m.—Martland Hospital, Newark Beth Israel, and VA Hospital, East Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

2 **Clinical Interpretations of Diagnostic Laboratory Tests**
3:30-5:30 p.m.—Rutgers Medical School, Piscataway
(Sponsored by CMDNJ, Rutgers Medical School, and Academy of Medicine)

2 **Monthly Meeting**
8-10 p.m.—Newark Beth Israel Medical Center, Newark
(Sponsored by New Jersey Gastroenterological Society and Academy of Medicine)

2 **Proper Use of Blood Gases**
2 p.m.—Christ Hospital, Jersey City
(Sponsored by Academy of Medicine)

2 **Proper Use of Blood Gases**
2 p.m.—Cherry Hill Medical Center, Cherry Hill
(Sponsored by Academy of Medicine)

2 9 16 23 30 **Distinguished Lectures in Neuroscience**
10:30-11:30 a.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)

3 **Proper Use of Antibiotics**
1:00 p.m.—Ancora Psychiatric Hospital, Hammonton
(Sponsored by Academy of Medicine)

3 10 17 24 **Clinical Nephrology**
4-5 p.m.—Martland Hospital Unit, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 12 19 26 **Orthopedic Surgery**
8:30 a.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 12 19 26 **Basic Science for Surgeons**
10 a.m.-12 noon—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 14 21 28 **Distinguished Lectures in Surgery**
4-5 p.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

8 **Office Surgery**
8 p.m.—White Laboratories, Schering Corporation
(Sponsored by New Jersey Dermatology Society and Academy of Medicine)

8 **Gastrointestinal Bleeding**
8 p.m.—Paul Kimball Hospital, Lakewood
(Sponsored by Academy of Medicine)

8 **Proper Use of Antibiotics**
10:30 a.m.—North Hudson Hospital, Weehawken
(Sponsored by Academy of Medicine)

9 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and the Academy of Medicine)

15 **Newer Concepts in Hepatitis Management**
12 noon—Hospital Center at Orange
(Sponsored by Academy of Medicine)

16 **Infertility**
11 a.m.—Margaret Hague Maternity Hospital, Jersey City
(Sponsored by Academy of Medicine)

16 **Hepatitis Management**
1:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(Sponsored by Academy of Medicine)

16 **Thanatology**
1 p.m.—Trenton Psychiatric Hospital, Trenton
(Sponsored by Academy of Medicine)

16 **Tuberculosis Before and After Chemotherapy**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

18 **Care of the Critically Ill Patient—Cardiac Arrests**
12 noon—Freehold Area Hospital, Freehold
(Sponsored by Academy of Medicine)

21 **Arteriography**
11:30 a.m.—Helene Fuld Hospital, Trenton
(Sponsored by Academy of Medicine)

22 **Hepatitis Management**
8 p.m.—Warren Hospital, Phillipsburg
(Sponsored by Academy of Medicine)

22 **Regional Chest Case Conferences**
7:30 p.m.—Christ Hospital, Jersey City
(Sponsored by New Jersey Thoracic Society and Academy of Medicine)

23 **Oral Manifestations of Systemic Disease**
9 a.m.-4 p.m.—VA Hospital, East Orange
(Sponsored by Academy of Medicine)

24 **Pancreatic Scanning**
7:15-10:15 p.m.—Hospital Center at Orange
(Sponsored by Radiology Society of New Jersey and Academy of Medicine)

25 **Medical Care in the Emergency Room**
12:15 p.m.—Zurbrugg Memorial Hospital, Riverside
(Sponsored by Academy of Medicine)

25 **Hepatitis Management**
9 a.m.—St. Elizabeth Hospital, Elizabeth
(Sponsored by Academy of Medicine)

May

1 8 15 22 29 **Clinical Nephrology**
4-5 p.m.—Martland Hospital Unit, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

3 10 17 24 **Orthopedic Surgery**
8:30 a.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

3 10 17 24 31 **Basic Science for Surgeons**
10 a.m.-12 noon—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 12 19 **Distinguished Lectures in Surgery**
4-5 p.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 **Clinical Endocrinology**
6 p.m.—Holiday Inn, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 **Fluid and Electrolyte Imbalance**
2 p.m.—Christ Hospital, Jersey City
(Sponsored by Academy of Medicine)

7
14
21
28 **Distinguished Lectures in Neuroscience**
10:30-11:30 a.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, East Orange VA Hospital, and Academy of Medicine)

7
14
21
28 **Clinical Interpretation of Diagnostic Laboratory Tests**
3:30-5:30 p.m.—Rutgers Medical School, Piscataway
(Sponsored by CMDNJ, Rutgers Medical School, and Academy of Medicine)

7
14
21
28 **Clinical Endocrinology**
3:30 p.m.—Martland Hospital, Newark Beth Israel Medical Center, and VA Hospital, East Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7 **Minor Surgery in Office Practice**
14 **Learning Disabilities**
21 **Nutrition of the Aged**
28 **Emotional Aspects of Common Medical Problems**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital)

13 **Hepatitis Management**
8 p.m.—Paul Kimball Hospital, Lakewood
(Sponsored by Academy of Medicine)

13 **Fluid and Electrolyte Imbalance**
12 noon—Hospital Center at Orange
(Sponsored by Academy of Medicine)

13 **Proper Use of Laparoscopy**
11 a.m.—Margaret Hague Maternity Hospital, Jersey City
(Sponsored by Academy of Medicine)

13 **Proper Use of Blood Gases**
10:30 a.m.—North Hudson Hospital, Weehawken
(Sponsored by Academy of Medicine)

14 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and the Academy of Medicine)

14 **Respiratory Failure**
11:30 a.m.-1 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

19 **Proper Use of Blood Gases**
8 p.m.—Irvington General Hospital, Irvington
(Sponsored by Academy of Medicine)

21 **Joint Monthly Sessions of Clinical Interest**
7-9 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, East Orange VA Hospital, and Academy of Medicine)

22 **Regional Chest Case Conferences**
7:30 p.m.—The Medical Center at Princeton
(Sponsored by New Jersey Thoracic Society, and Academy of Medicine)

23 **Proper Use of Blood Gases**
9 a.m.—St. Elizabeth Hospital, Elizabeth
(Sponsored by Academy of Medicine)

27 **Psychiatry**
8 p.m.—Warren Hospital, Phillipsburg
(Sponsored by Academy of Medicine)

28 **Annual Awards Dinner**
6 p.m.—Chanticler, Millburn
(Sponsored by Academy of Medicine)

May 31-June 3
Annual Meeting, MSNJ
Garden State Convention Center, Cherry Hill

June

4 **Clinical Endocrinology**
3:30 p.m.—Martland Hospital, Newark Beth Israel Medical Center, and VA Hospital, East Orange (varies)
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

5 **Thanatology**
1 p.m.—Ancora Psychiatric Hospital, Trenton
(Sponsored by Academy of Medicine)

7 **Orthopedic Surgery**
8:30 a.m.—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

7
14
21
28 **Basic Science for Surgeons**
10 a.m.-12 noon—Martland Hospital, Newark
(Sponsored by CMDNJ, New Jersey Medical School, and Academy of Medicine)

10 **Difficult Diabetic Patient**
8 p.m.—Paul Kimball Hospital, Lakewood
(Sponsored by Academy of Medicine)

11 **Monthly Neuroradiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital, Morristown
(Sponsored by Radiological Society of New Jersey and the Academy of Medicine)

18 **Joint Monthly Sessions of Clinical Interest**
7-9 p.m.—VA Hospital, East Orange
(Sponsored by CMDNJ, New Jersey Medical School, East Orange VA Hospital, and Academy of Medicine)

24 **Hepatitis, Acute and Chronic**
11 a.m.—Perth Amboy General Hospital, Perth Amboy
(Sponsored by Academy of Medicine)

24 **Thyroid Diseases**
8 p.m.—Warren Hospital, Phillipsburg
(Sponsored by Academy of Medicine)

27 **Endotoxic Shock**
9 a.m.—St. Elizabeth Hospital, Elizabeth
(Sponsored by Academy of Medicine)

Breast self-examination:

KEY ROLE OF THE PHYSICIAN

item:	**Breast cancer is a major concern of American women, according to a recent Gallup study conducted for the American Cancer Society.**
item:	**Although aware that early discovery improves the chances of cure, and that BSE can lead to early discovery, *fewer than 1 in 5* women practice BSE, and *only half* have an annual breast examination by a physician.**
item:	**Only 35% of all women polled reported that a *physician* had ever raised the subject of breast self-examination, and only 24% had received instruction from the physician on how to do it. Even among women who regularly see a gynecologist, only 34% had been instructed on BSE.**
item:	***But,* among women who received personal instruction from their physicians, the overwhelming majority *(92%)* practiced BSE during the preceding year.**

The Gallup study revealed that, far more important than increasing awareness of breast self-examination, is the problem of inducing women to practice it regularly. The physician plays a key role in this—by teaching women the correct technique, and instilling in them the confidence that will assure their continued practice of BSE.

The American Cancer Society gives major emphasis to breast cancer through research and a vast array of public educational materials, designed to give women life-saving information about the disease. Our latest approach is via a pioneering television film starring Jennifer O'Neill, "Breast Cancer: Where We Are." Where we *will* be in a few years will certainly hinge on our joint efforts.

American Cancer Society®

NEW JERSEY DIVISION
2700 Route 22 PO Box 1220
Union, N.J. 07083

ADVERTISING RATES AND DATA January 1975

the JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

THE JOURNAL IS A UNIQUE MEDIUM—it is the only publication that prints news about New Jersey State activities and activities within the State in terms of a physician whose practice is in this State. Countless items could be detailed whereby our editorial and scientific copy constitutes the primary, if not the only, source of information of vital interest to our members. Here are a few: decisions of the Board of Trustees of the Society; clinic, convention, meeting announcements; state legislation; communicable diseases; medical insurance; PSRO, education, etc.

Further, THE JOURNAL is a unique medium as it provides for the publication of scientific articles pertinent to the practice needs and interests of our members. These scientific articles are written by respected, known colleagues of our members. Authors, who number from a dozen upwards per issue, are personally involved in THE JOURNAL—and their friends and fellow members are involved also.

THE JOURNAL PROVIDES AN EXCELLENT DEMOGRAPHIC PROFILE WITHIN A SPECIFIC GEOGRAPHIC AREA. General Practitioners as well as specialists are the readers of our advertisements. Within the practice of medicine, we offer a total market; within the geography of our nation and the geography of seasonal, geographic medical needs, we offer a specific market at a saturation level provided by no other publication.

A 1973 MEASUREMENT OF ADVERTISING PAGE TRAFFIC (READERSHIP) of state journals yielded a net traffic measure of 36.1% with no seasonal variation in traffic. The study conducted by Professional Research Analysts clearly shows that state journals are trafficked more than most professional journals. Additional studies are now underway.

circulation

9,294

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GENERAL INFORMATION

1. **GUARANTEED CIRCULATION: 8,750**

2. **1974 MONTH AVERAGE CIRCULATION: 8,832**

3. **MEMBERSHIP CIRCULATION BY COUNTIES OF STATE OF NEW JERSEY**

Atlantic	203
Bergen	1,047
Burlington	245
Camden	534
Cape May	50
Cumberland	116
Essex	1,791
Gloucester	103
Hudson	559
Hunterdon	66
Mercer	552
Middlesex	475
Monmouth	514
Morris	469
Ocean	206
Passaic	726
Salem	41
Somerset	162
Sussex	73
Union	766
Warren	61
Figures as of 10-31-74	Total 8,759

4. **TRADE CIRCULATION:**

Medical Libraries, etc.
Drug Manufacturers
Medical Book Publishers
Medical Abstract Services
Advertisers
Advertising Agencies
Subscriptions
Total Approximately 550

5. **ADVERTISING DEADLINES:**

Space reservations	1st of preceding month
Complete film	10th of the previous month
Inserts	1st of the month
Cancellations	before 1st of the previous month
Proofs	mailed to advertiser about 15th of month
Approved proof due	21st of the month

6. Acceptability: All advertising is subject to acceptance by Publications Committee whose members are Daniel B. Roth M.D. Chairman, Julio C. del Castillo, M.D., and John F. Marshall M.D.

7. Mailing Dates: 5th-6th of Month.

8. Editorial-Advertising Ratio: 55%/45% average.

9. Subscription Rates: $10.00 per year

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a. Display

	1 time	3 times	6 times	12 times
1 Page	$235	$220	$205	$190
½ Page	130	120	110	100
¼ Page	65	60	55	50
⅛ Page	45	40	35	30

Prices listed are per insertion

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½ vertical	3⅜	X	10
¼ horizontal	7	X	2⅜
¼ vertical	3⅜	X	4⅞
⅛ horizontal	7	X	1⅛
⅛ vertical	3⅜	X	2⅜

Pages are 2 columns, each 2⅞"

b. Inserts:
Untrimmed size—8¼ x 11¼

c. Bleed Pages:
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Trim size—8 x 11

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OBITUARIES

Dr. Louis K. Collins

On October 28, 1974, Louis Keeler Collins, M.D., the 175th President of The Medical Society of New Jersey, died at his home after a lengthy illness. (See editorial, page 913 this issue.) A general practitioner with special interest in proctology, Dr. Collins earned his medical degree from Jefferson Medical College, class of 1934, and served a 27-month internship at his alma mater, followed by a year of travel as ship's surgeon aboard a private yacht. In 1937, he established a practice in Glassboro and, with time out for a three-and-a-half-year tour of duty as flight surgeon during World War II, served the people of that area until retirement last June.

Dr. Collins had been president of his County Medical Society and at the State level he was a member of the Board of Trustees prior to advancing to the presidency; following that he served as a member and chairman of the Council on Medical Services.

For twenty years, Dr. Collins was a member of the faculty at Jefferson Medical College as clinical assistant in the department of proctology. He was a Fellow and charter member of the American Academy of Family Practice and a member of the attending staff at the Community Hospital in Elmer. He was 63 years old at the time of his death.

Dr. Hugo S. DeLuca

At the untimely age of 44, Hugo S. DeLuca, M.D., a member of our Gloucester County component, died at University of Pennsylvania Hospital on September 9, 1974. Born in New York, Dr. DeLuca earned his medical degree from the State University of New York (Brooklyn) in 1956 and took residencies in orthopedic surgery at the Naval Hospital in Philadelphia and at the DuPont Institute for Crippled Children in Wilmington. He remained with the military until 1966, when he accepted a position as clinical associate in orthopedics at the Medical College of South Carolina. In 1967 he came to Woodbury to establish a practice in his chosen field and was on the staff at the Underwood Memorial Hospital there. He was a Fellow of the American College of Surgeons and a member of the American Academy of Orthopedic Surgeons. Dr. DeLuca was interested in sports medicine and was formerly assistant physician with the Philadelphia Eagles and had coached football at several naval bases during his ten years of Navy duty.

Dr. Madeline Kahrs-Dreyfors

Word has just been received from Florida of the death there in November 1972 of Madeline Kahrs-Dreyfors, M.D., formerly director of the department of pathology at Marlboro State Hospital. Born in 1893, she was graduated from New York Medical College for Women in 1917 and pursued a career in pathology, becoming board certified in both clinical and anatomical pathology. She was active in community affairs and had been a member of the board of directors of the Allenwood Hospital and director of the venereal disease control clinic in Marlboro. Dr. Kahrs-Dreyfors retired to Florida in 1957 but retained membership in The Medical Society of New Jersey.

Where We Stand

Where We Stand, a pamphlet delineating MSNJ's official position on medical and health issues, is available upon request from the Public Relations Office, MSNJ, P.O. Box 904, Trenton, New Jersey 08605.

BOOK REVIEWS

Questions and Answers About Medical Electronics. Edward J. Bukstein. Indianapolis, Sams and Company, 1970. Pp. 95. Illustrated ($2.95)

Introduction to Biochemical Electronics. Edward J. Bukstein. Indianapolis, Sams and Company, 1973. Pp. 208. Illustrated. ($5.50)

Servicing Biochemical Equipment. Elliott S. Kanter. Indianapolis, Sams and Company, 1974. Pp. 160. Illustrated. $5.50)

These three books which have been long awaited by physicians offer an easy way for doctors to comprehend the various techniques, applications, and equipment involved in biomedical electronics. They are of interest also to the non-physician who must work with this type of equipment and to physicians who must have more than a casual acquaintance with the application of electronic equipment through medicine.

Perhaps this reviewer, with his previous background in electronics, may seem to have an advantage over the physician who is not formally trained in electronics, but I think this is not the case. The books are well written, clearly thought out, and the subject matter organized in a most logical way. I feel that one should read these books in the sequence presented in the title of this review.

Physicians who use any type of patient monitoring, which probably encompasses all practicing physicians today, should have a knowledge, even though it may be minor, of biomedical electronics. In the light of the present day advances in medicine, it is the obligation of physicians to make a cursory knowledge of electronics part of their armamentarium. These three books, which can be read quickly, will provide a large amount of the information necessary to fill the gap.

Philip L. Kauff, B.E.E., M.D.

Cardiac Arrest and Resuscitation. 4th Edition. Hugh E. Stephenson, Jr., M.D. St. Louis, Mosby 1974. Pp. 998. Illustrated. ($45.50)

This book, which deals with sudden unexpected death and what to do about it, is really two books under one cover. One portion deals with cardiac arrest, which the author states, in his introduction, "is the most common mode of death in our adult population;" the other portion describes methods which would undo the arrest. Such a momentous subject certainly requires a complete answer, all of which the author furnishes, assisted by an elite group of medical experts.

The first part of this book describes the problems of sudden death with special attention to detection, avoidance of risk factors, and mechanisms involved. Although the majority of cases are found in people with arteriosclerotic heart disease who suffer an acute myocardial infarction, there are also many examples among patients who are anesthetized, undergo surgery, neurological cases, exsanguinations, drug reactions, vagal reactions, anoxia, and miscellaneous groupings. The doctors who treat such dramatic episodes include internists, cardiologists, surgeons, anesthetists, neurosurgeons, and pediatricians, so it behooves all such individuals to be cognizant of the contents of this book.

The second section of this encyclopedic compilation describes in the broadest terms, but with painstaking detail, all of the aspects of cardiac resuscitation. This material is a wholesome mix of simple, practical, pragmatic instruction coupled with advanced, sophisticated, scientific theory.

The literary style varies from contributor to contributor, but the main portion of this book by the primary author, Dr. Stephenson, is very readable. He uses a warm personal anecdotal technique in some of the chapters, which is a great change of pace from the usual text but refreshing in its typical midwestern candor and "folksy" style. It reads like a storybook as the author tells about the trials and tribulations that transpired at St. John Hospital, Springfield, Missouri, as the new ideas about cardiac resuscitation were implemented.

This book has 998 pages, 68 chapters, and hundreds of bibliography listings, and contains the latest information for all members of the medical profession—interns, residents, nurses, paramedics, ambulance attendants, emergency room personnel, and hospital administrators. All facets of this formidable problem are presented, discussed and evaluated. It is certainly the most complete text on the subject of cardiac arrest and resuscitation.

Manuel J. Rowen, M.D.

Handbook of Medical Treatment, 14th Edition. Edited by Milton J. Chatton, M.D. Los Altos, California, Lange, 1974. Pp. 640. (Softback-$7.50)

This little handbook of treatment is divided, like most full-sized tests, into divisions for each organ system, infectious diseases, nutritional and hormone problems, toxins, other physical agents, and cancer chemotherapy. Each sickness or disorder is briefly described. Then appropriate therapy is given in an organized fashion, concise but complete, and easy to follow.

I think this little softback is a gem. It will fit into any large pocket or medical bag and is valuable for quick reference. I have carried a copy in my car for some time and often find it useful.

I would recommend it to any practitioner who must look up some aspect of therapy quickly and does not have a medical library right at hand.

Leo Lewin, M.D.

Hospital Computer Systems. Edited by Dr. Morris F. Collen. New York, John Wiley & Sons, 1974. Pp. 768. Illustrated. ($28.50)

Included among the hospital computer systems and individual department sub-systems described in this book are administrative, nursing station, clinical laboratory, pathology, radiology, physiological monitoring, multiphasing screening, preventive health maintenance and research, and medical education systems and subsystems. Special attention is given to the medical computing applications.

Experience in using a computer system is clearly shown in terms of the evaluation of hardware and software, service and contract, personnel orientation, experimental nature of some systems, expansion, cost-benefit models, and management studies.

Six chapters are added in the book, each covering a case evaluation of a hospital computer system from its planning, installation, and utilization stages.

Medical professionals and hospital administrators will find this book useful for the comparison and planning of the installation of a computer system.

Shirish J. Shastri, Ph.D.

Microbiology and Infectious Disease. B. A. Briody, Ph.D. and R. E. Gillis, D.D.S. New York, McGraw-Hill, 1974. Pp. 707. Illustrated. (Price not stated)

The title of this book indicates an interesting change in purpose and presentation from the conventional textbook of microbiology. The authors and contributors have attempted to make this book similar to the format of texts used in the clinical disciplines of medicine, surgery, obstetrics, and pediatrics. I think they have satisfied their aim admirably. In the first eleven chapters are covered (1) basic microbiology—microbial structure, physiology, genetics and pathogenic determinants, (2) host factors in infection, (3) immunology consisting of the antigen-antibody reactions, hypersensitivity, immunohematology, transplantation, and autoimmunity and (4) mechanisms of chemotherapy.

The other sixteen chapters deal separately and emphasize the diseases (1) of similar pathogenicity and epidemiology, e.g., mycobacterial infections, venereal infections, and so on, and (2) of diseases involving various organ systems, e.g., enteric and urinary infection, eye and ear, central nervous system, and so on. In some cases of the latter group, infections of a specific organ system are categorized both as "localized infections" and also as "systemic infection with local involvement."

The material is extensively and completely covered with good tables and illustrations; it is well organized; the bibliography is up-to-date.

This is a very readable book and is recommended for medical students, house staff, and practitioners who seek in one textbook a mixture of microbiology and infectious diseases.

Dominic A. Mauriello, M.D.

Shock in Myocardial Infarction. R. M. Gunnar, H. S. Loeb, and S. H. Rahimtoola, New York, Grune and Stratton, 1974. Pp. 277. Illustrated. ($17.50)

Doctor Gunnar and his associates have put together a rather complete review of shock complicating myocardial infarction. It is obvious in the reading of this monograph that the authors have difficulty in defining the physiologic parameters of shock in myocardial infarction. Studies done on a clinical level are of limited number and have only recently been added to our armamentarium. The studies that are more readily available tend to be in animals where shock is, at best, transitory. Most of the authors spend a great deal of time reviewing not only the pathophysiology and therapy of shock in infarction, but also normal physiology and pathology of the heart and circulation. The individual articles are well referenced so that one gets a broad view of the literature and the book then serves as a reference work for the field of myocardial infarction, coronary and myocardial physiology, and shock.

Unfortunately all of the work accumulated in this book appears to have been published elsewhere. Indeed one or two chapters are almost completely extracted from articles by the same authors. The material is technical in large part so that the book-appeal will be contained to a fairly small audience in the field of medicine—people working in cardiology at a fairly technical level.

The chapters which stand out as being particularly useful are those by the editors themselves who have had a great deal of experience in this field and have an excellent overview of the subject. Despite the fact that it has been published elsewhere almost in its entirety, Dr. Swan's chapter on "The Functional Basis of the Hemodynamic Spectrum Associated with Myocardial Infarction" does review some physiologic principles. With this knowledge one may better approach the patient with acute myocardial infarction.

The remainder of the book has little practical application, especially in view of the dire prognosis associated with myocardial infarction and shock. And, most hospitals do not have the monitoring techniques for handling such patients.

M. Jay Goodkind, M.D.

Detection of Hemoglobinopathies. R. M. Schmidt, T. H. J. Huisman, and H. Lehman. Cleveland, CRC Press, 1974. Pp. 101. Illustrated. ($10.95)

This volume of some 100 pages is a compilation of papers presented at the conference held in Atlanta, Georgia in 1973. The conference was composed of 60 participants from 26 countries and the papers presented formed a basis for international agreement on the state of the health in the increasingly important field of abnormal hemoglobin and thalassemia. These papers were unique in that they dealt with diseases primarily of a genetic origin. Since the discovery of hemoglobin S in 1949, more than 160 variants of human hemoglobins have been described. In a World Health Organization (WHO) meeting in 1966, it was noted that whereas 5 of 100,000 children born might die of childhood leukemia, 2,000 to 100,000 children born in parts of tropical Africa could be expected to have sickle cell anemia. The papers dealing with electrophoresis, chromatography, sickling tests, and diagnostic criteria for thalassemia are recorded in the text. The volume merits reading, however, it is the reviewer's opinion that such material as the peptide mapping of hemoglobin and column chromatography of hemoglobin peptides belongs entirely to the academic world.

Thomas K. Rathmell, M.D.

Planning for Cardiac Care. C. W. Clipson and J. J. Wehrer, Anne Arbor, Michigan, Health Administration Press, 1973. Pp. 407. Illustrated. ($20—softback)

This giant-sized paperback, 9" x 12" in size, is a book which is encyclopedic in scope, covering every possible facet of the health care facility commonly called "The Coronary Care Unit".

The modern day management of myocardial infarction became of age with the realization that most coronary deaths were arrhythmic in nature and with the almost simultaneous development of a technology capable of demonstrating these arrhythmias. Early Coronary Care Units required structural renovations of existing hospital areas and in most cases the inefficiencies inherent in "making do" were very apparent. In planning for new construction, there was usually insufficient interchange between the architect, hospital administrator, Board of Trustees, and medical and nursing staff.

Only after the unit was constructed and in operation, and no longer capable of being changed, were the errors of poor planning recognized.

The purpose of this excellently written volume is to provide the hospital planning team, the hospital architect, and those in all the hospital echelons of patient care with the information they need to develop an efficiently working Coronary Care Unit. It covers everything from structure to instrumentation, to personnel, to methods of operation. For the architect it provides extensive information on procedural aspects of the cardiac care process. For the planners it provides illustrative units from which they can develop one which suits their needs most. An entire chapter is devoted to the system of cardiac care from risk factors through the attack itself, to the mobile Coronary Care Unit, to the hospital Coronary Care Unit, and then progressively on to less intensive care monitored by telemetry, and finally back into the community, describing, in effect, a coordinated comprehensive community health care system. The book is profusely illustrated with pictures, diagrams, and charts. It has all the answers and should be in the library of every hospital architect and hospital administrator.

Harry E. Nussbaum, M.D.

Strategic Intervention in Schizophrenia. R. Cancro, N. Fox, and L. Shapiro. New York, Behavioral Publications, 1974. Pp. 326. ($14.95)

This book is a collection of twelve papers, written by as many authors, concerning the treatment of schizophrenia. Six of the papers are reruns of presentations delivered in a symposium on schizophrenia in 1973. The author of each chapter discusses a specific mode of treatment. Included are individual, group, and family techniques; somatic, pharmacological, and behavioral methods; and discussions on brief hospitalization and rehabilitation.

It may be noted that the articles are strongly biased in many instances, propounding the methods of the authors. For example, Dr. H. Lehmann allows himself to be manipulated by his patients when he provides megavitamin therapy if patients insist on it, since "possible adverse affects are not . . . a very serious threat: . . . provided it would be administered with . . . standard treatment." This is definitely not a textbook, but rather a collection of papers that are general in nature. Details of treatment techniques are not mentioned.

It is a book that the psychiatrist will find pleasant to read and engrossing, but I doubt if he will gain too much new information. In the interest of the consumer, this book is cheaply bound and printed on pulp paper, and is overpriced at $14.95.

Seymour F. Kuvin, M.D.

Oral Health, Dentistry, and the American Public: The Need for an Improved Oral Care Delivery System. William E. Brown, D.D.S., Editor. Norman, Oklahoma, University of Oklahoma Press, 1973. Pp. 372. (Price not given)

A review of a dental treatise may not seem relevant and material to the medical profession. However, this series of expert, readable, reasonable, informative, and enjoyable position papers may be readily transposed into a model for medical concern. Six members of the Advisory Committee on Dental Health Research and Education, under the auspices of National Institute of Health, agreed to undertake a project which would identify the present state of the dental art and areas of the knowledge shortfalls. Completed papers were subject to critiques and the papers and selected critiques are published in this volume. They cover an extensive number of subjects from the state of dental art in periodontal disease, to the funding of dental care with equity and efficiency, the evaluation of quality of care, and the training and utilization of manpower utilizing the concept of varied means of entrance and entrance into the profession or auxiliary services plus other challenging subjects of concern to health professionals.

This self analytical technique of evaluation, prepared by the nation's second largest group of health professionals, contains enough new clinical material to be of interest to physicians concerned with the general health of his patients but far more consideration of a vast array of socio-economic problems that are presently on center stage and clustered in the wings of the health-care theatre.

One group of health professionals has recognized that the "greatest danger . . . is not invasion of health fields by the government but rather the loss of leadership by the health professionals" and has undertaken critically to understand their own present roles and prepare themselves for further larger and more realistic roles. Recommended reading.

James E. D. Gardam, M.D.

Review of Medical Pharmacology. 4th Edition. F. H. Meyers, E. Jawetz, and A. Goldfien, Eds. Los Altos, California, Lange, 1974. Pp. 721. Illustrated. (Softback—$10.50)

This review accomplishes its objectives admirably. It covers the field of therapeutic pharmacology. Basic considerations in drug therapy are succinctly restated. Certain aspects, such as drug interactions and drug abuse, are topical. Rational approaches to drug selection are explained. Tabulations assist in presenting the multiplicity of available drugs in certain therapeutic areas. Some invited authors have contributed up-to-date, excellent, well-referenced chapters on selected topics, such as cancer chemotherapy and antihelmintics.

I considered the advantages this book might have over a standard hardcover textbook. Lower price is an obvious one, and this is balanced against the absence of much historical and experimental information. The major advantage is that it is up-to-date and will be revised and reissued every two years. This timeliness is enhanced by the inclusion of drugs which are still investigational in the United States, but which may be approved for use within the next two years.

This review has value as an updating supplement to a full standard textbook or as a means of rapid review of a topic, when access to a library or facility in finding review articles in journals is not present.

Hyman W. Fisher, M.D.

209th Annual Meeting

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